

**Kentucky Department of Insurance**  
**Division of Health Insurance Policy and Managed Care**  
**Health Care Financing Branch**  
**\*RATE FILING INFORMATION FORM (Limited Benefits)**  
 \* (This form is not required with Health Benefit Plan Rate Filings in KRS 304.17A)

Company	NAIC Company No.
Contact Person	E-Mail Address
Phone No. (800 # if available)	EXT.
	Fax Number

Form No(s).	No of Forms
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**CHECK ALL APPLICABLE: \* This does not apply to Health Benefit Rate Filings**

**TYPE OF POLICY:**

<input type="checkbox"/> Accident	<input type="checkbox"/> Hospital Indemnity	<input type="checkbox"/> Medicare Supplement -Standardized
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hospital/Medical/Surgical	<input type="checkbox"/> Short-Term Nursing Home
<input type="checkbox"/> Dental	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Student
<input type="checkbox"/> Disability	<input type="checkbox"/> LTCPI (LTC Partnership Insurance)	<input type="checkbox"/> Vision
<input type="checkbox"/> Home Health	<input type="checkbox"/> Medicare Supplement Pre-Standardized	<input type="checkbox"/> Other _____

**REQUIRED ANNUAL MEDICARE SUPPLEMENT FILING:** ( )

**MARKET TYPE:** ( ) Individual ( ) Group ( ) KY Retirement/Group Seniors

<b><u>AVAILABILITY:</u></b>	<b><u>PREMIUM STRUCTURE:</u></b>
<input type="checkbox"/> Closed Block	<input type="checkbox"/> Open Block
	<input type="checkbox"/> Attained Age
	<input type="checkbox"/> Issue Age
	<input type="checkbox"/> Community
	<input type="checkbox"/> Other _____

**RENEWAL CATEGORIES:**

<input type="checkbox"/> OR-Optionally renewable	<input type="checkbox"/> CR- Conditionally renewable
<input type="checkbox"/> GR- Guaranteed renewable	<input type="checkbox"/> NC- Noncancelable

**FILING INFORMATION:**

Range in Rate Structure (area, age slope, etc.) Yes _____ No _____	Previous Rate Filing DOI # _____
Rate % Increase Requested: _____	Range of Rate Increase: _____
Estimated Average Annual Premium <i>before</i> Increase: _____	
Estimated Average Annual Premium <i>after</i> Increase: _____	
No. of Kentucky Policies: _____	No. of National Policies: _____
Requested Filing Effective Date: _____	Original Filing Date: _____
Previous Increase Effective Date: _____	Amount of Last Approved Increase: _____