LICENSEE CONTACT INFORMATION FOR ACCIDENT AND HEALTH INSURERS

Complete the following information for each licensed company or line of business. If providing information for more than one licensed company or line of business, submit separate sheets for each.

1. Insurer / HMO Name ____

2. Address ____

____
(city) (state) (zip)

3. Identify Licensure Type (Please Check Only One. If More than One Applies, Please Complete Additional Sheets for Each Licensee):

[ ] Accident and Health Insurance Company
[ ] Continuing Care Retirement Communities
[ ] HMO
[ ] Municipal Cooperative Health Benefit Plan
[ ] Article 43 Corporation
[ ] Fraternal Benefit Society
[ ] Life Insurance Company
[ ] Property Casualty Company

4. Identify the accident and health insurance coverage you are currently offering under the licensure type identified in (3) above and identify the markets in which the coverage is offered (Check all that apply):

*Key for Markets: Individual **(IND)** Small group (2- 50 lives) **(SG)** Large group (51 and above) **(LG)** Blanket* **(B)**

Coverage	**Markets**			
[ ] Accident Only	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Accidental Death and Dismemberment	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Continuing Care Retirement Community	[ ] IND	[ ] SG	[ ] LG	
[ ] Dental Only	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Disability Income	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] HMO	[ ] IND	[ ] SG	[ ] LG	
[ ] Hospital Indemnity	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Hospital, Surgical, and/or Medical Expense	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Long Term Care	[ ] IND	[ ] SG	[ ] LG	
[ ] Long Term Care Partnership	[ ] IND	[ ] SG	[ ] LG	
[ ] Medicare Supplement/Select	[ ] IND	[ ] SG	[ ] LG	
[ ] Nursing Home and/or Home Care	[ ] IND	[ ] SG	[ ] LG	
[ ] Prescription Drug	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Provider Excess Loss	[ ] IND	[ ] SG	[ ] LG	
[ ] Specified Disease	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Statutory Conversion (Ins. Law §3221(e))	[ ] IND	[ ] SG	[ ] LG	
[ ] Statutory Disability Benefits Law (DBL)	[ ] IND	[ ] SG	[ ] LG	
[ ] Stop Loss			[ ] LG	
[ ] Travel Insurance	[ ] IND	[ ] SG	[ ] LG	[ ] B
[ ] Vision Only	[ ] IND	[ ] SG	[ ] LG	[ ] B

5. Authority to Write:

[ ] Authorized to write and currently writing accident and health insurance.
[ ] Authorized to write accident and health insurance, but not currently writing, and have existing closed blocks of such coverage.
[ ] Authorized to write accident and health insurance, but not currently writing, and do not have any closed blocks of such coverage.

6. **Identify the government programs you participate in under the licensure type identified in (3) above (Check all that apply):**

[ ] Child Health Plus [ ] Medicaid Managed Care
[ ] Family Health Plus [ ] Medicare Advantage
[ ] Healthy New York [ ] Medicare Part D

7. **If your company is a Commercial Insurer, an Article 43 Corporation, or a Municipal Cooperative Health Benefit Plan that includes health insurance coverage through a network of participating providers, identify the following for each preferred provider organization (PPO) and exclusive provider organization (EPO) Product:**

The policy form number of the PPO product	The marketing name of the PPO product	The number of insureds covered under the PPO product (as of 12/31/07)

The policy form number of the EPO product	The marketing name of the EPO product	The number of insureds covered under the EPO product (as of 12/31/07)

8. **If your company is currently writing accident and health insurance coverage, provide the following contact information for:** (A) the government relations contact person you would like us to contact with complaints and inquiries, (B) the regulatory compliance contact person you would like us to contact regarding policy form issues, (C) your company's chief executive officer, (D) your company's annual statement contact person, (E) your company's chief actuary, (F) the person you would like us to contact with respect to the Regulation 146 Specified Medical Condition Pools, (G) the person you would like us to contact with respect to the Healthy New York Program and (H) the person you would like us to contact for preferred provider organization quality assurance information.

A. Name of Contact Person for Complaints / Inquiries ____________________

Address if different from item (2) above ____________________

Telephone Number____________________ Fax Number ____________________

E-mail Address ____________________

B. Name of Contact Person for Policy Forms ____________________

Address if different from item (2) above ____________________

Telephone Number____________________ Fax Number ____________________

E-Mail Address ____________________

C. Name of Chief Executive Officer ____

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____

D. Name of Annual Statement Contact Person ____

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____

E. Name of Chief Actuary ____

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____

F. Name of Regulation 146 Contact Person ____

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____

G. Name of Healthy New York Contact Person ____

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____

H. Name of Contact Person for PPO / EPO Quality Assurance Information ____________________________

Address if different from item (2) above ____

Telephone Number______________________________ Fax Number ____________________________

E-Mail Address ____