Issuer Participation Intent Form

Submitter's Name	
Submitter's Email Address	
Submitter's Telephone Number	

Organization Information	
Issuer Legal Name	
Issuer Marketing Name (d/b/a)	
Date Kentucky Certificate of Authority Received	
NAIC Number	
Federal Employer Identification Number	
HIOS ID	
Type of Organization (Indicate Insurer, Health Maintenance Organization, Non-Profit Health Service Plan, Limited Health Service Organization, Multi-State Plan, or Consumer Operated and Oriented Plan)	
Accreditation Status (Identify if URAC, NCQA has been awarded and whether this is for Medicaid or Commercial products. If no accreditation has been awarded, please enter "NONE")	
Planned Exchange Market (*Note:* whether the issuer will have plans in the Individual Exchange and/or the SHOP Exchange)	
Product Type (Provide product types that may be offered HMO, PPO, POS, etc.)	
Planned Service Area (Provide a list of Kentucky counties that will be covered by Plans/Networks)	

Organization Contact Information	
Primary Implementation Contact (Contact for System Access and Plan Submission) • Name • Title • Phone • Email Address	
Primary Marketing Contact (Contact for Marketing, Communications, Outreach) • Name • Title • Phone • Email Address	
Authorized Contracting Official (Contact for Business Agreement) • Name • Title • Phone • Email Address	