

Kentucky Office of Health Data and Analytics
Kentucky Access GAP Program

Supporting Insurer's and Stop-Loss Carrier's Quarterly Report
(Due Within Thirty Days After The End Of Each Calendar Quarter)

Insurer/Carrier: _____ Federal Tax Id. No.: _____
D/B/A: _____
P.O. Box: _____ Street: _____
City _____ State: _____ Zip: _____
NAIC No: _____ NAIC Group No.: _____
Phone: _____ (Area Code) _____ Fax: (Area Code) _____
Toll Free No: _____ E-mail Address: _____
Contact Person: _____ Position Title: _____

Note: Include information pertaining to health benefit plans. Exclude information pertaining to employees of the Commonwealth of KY, Medicare beneficiaries, Medicaid recipients, and CHAMPUS insureds.

REPORTING PERIOD: Year: _____ (check one) Qrt: 1st _____ 2nd _____ 3rd _____ 4th _____

TYPE OF INSURER: (Check Both if Applicable) Supporting: _____ Stop-Loss Carrier: _____

TOTAL STOP-LOSS HEALTH INSURANCE PREMIUMS EARNED FOR THIS QUARTER: \$ _____

TOTAL NUMBER OF HEALTH BENEFIT POLICIES IN FORCE BY MARKET TYPE AT THE END OF THIS REPORTING QUARTER: (Exclude Stop-Loss Policies)

Individual	_____	Small Group	_____
Large Group	_____	Association	_____
Employer Organized Association	_____		

TOTAL HEALTH BENEFIT PREMIUMS EARNED DURING THIS REPORTING QUARTER:

(Exclude Stop-Loss Premiums): \$ _____

TOTAL HEALTH BENEFIT PREMIUMS EARNED BY THE FOLLOWING MARKET TYPES DURING THIS REPORTING QUARTER: (Exclude Stop-Loss Premiums): (The sum of the following Health Benefit Premiums earned by market type must equal the amount reported above for Total Health Benefit Premiums):

Individual:	\$ _____	Small Group:	\$ _____
Large Group:	\$ _____	Association:	\$ _____
Employer Organized Association:	\$ _____		

I, _____, certify the accuracy and validity of the information contained in this report.
Please Print

(Date) (Signature) (Position Title)