Medicare Supplement Multiple Policy Report

Company Name: _____ Due: March 1st Annually

Company Address: _____

_____

Company NAIC Number: _____ Oklahoma Co. Number: _____

Contact Person: _____ Phone Number: _____

Email Address: _____

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

[**Source:** Added at 9 Ok Reg 549, eff 12/13/91 (emergency); Added at 9 Ok Reg 2499, eff 6/26/92; Amended at 9 Ok Reg 3899, eff 8/24/92 (emergency); Amended at 10 Ok Reg 1475, eff 5/1/93]