# TITLE 365. INSURANCE DEPARTMENT
# CHAPTER 10. LIFE, ACCIDENT AND HEALTH
# SUBCHAPTER 5. MINIMUM STANDARDS; CONTRACT GUIDELINES

## PART 13. MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

### 365:10-5-129.1. Guaranteed Issue for Eligible Persons

(a) **Guaranteed Issue.**

(1) Eligible persons are those individuals described in subsection (b) who apply to enroll under the policy not later than sixty-three (63) days after the date of the termination of enrollment described in subsection (b), and who submit evidence of the date of termination, disenrollment or Medicare Part D enrollment with the application for a Medicare supplement policy.

(2) With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subsection (c) that is offered and is available for issuance to new enrollees by the issuer, shall not discriminate in the pricing of such a Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such a Medicare supplement policy.

(b)**Eligible Persons.** An eligible person is an individual described in any of the following paragraphs:

(1) **Employee welfare benefit plan.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all or substantially all supplemental health benefits to the individual.

(2) **Medicare Advantage.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(A) The certification of the organization or has been terminated;

(B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material

provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) **Organizations.**

(A) The individual is enrolled with:

(i) An eligible organization under a contract under Section 1876 (Medicare risk or cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or

(iv) An organization under a Medicare Select Policy; and

(B) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 365:10-5-129.1(b)(2).

(4) **Medicare supplement.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or because of other involuntary termination of coverage or enrollment under the policy;

(B) The issuer of the policy substantially violated a material provision of the policy; or

(C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) **Termination of enrollment and subsequent enrollment.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare risk or cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act or a Medicare Select Policy; and an organization under an agreement under section 1833(a)(1)(A) (health care prepayment plan), or a Medicare Select policy; and the subsequent enrollment under this subparagraph is terminated by the enrollee during any period within the first twelve (12) months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or

(6) **Medicare Advantage disenrollment**.

(A) The individual, upon first becoming eligible for benefit under Part A of

Medicare at age 65, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(B) An individual, under age 65, who first becomes eligible for Medicare Part B and enrolls in a Medicare Advantage plan under part C of Medicare, and disenrolls from the plan by not later than twelve (12) months after the effective date of enrollment.

(7) **Part D Benefit Enrollment.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in Subsection 365:10-5-129.1(e)(4).

(c) **Guaranteed issue time periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(1), the guaranteed issue period begins on the later of the date the individual receives a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days thereafter;

(2) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(3), (b)(5) or (b)(6) whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;

(3) In the case of an individual described in Section 365:10-5-129.1(b)(4)(A), the guaranteed issue period begins on the earlier of the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and the date that the applicable coverage is terminated, and ends on the date that is sixty-three (63) days after the date the coverage is terminated.

(4) In the case of an individual described in Section 365:10-5-129.1(b)(2), (b)(4)(B), (b)(4)(C), (b)(5) or (b)(6) who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

(5) In the case of an individual described in Subsection 365:10-5-129.1(b)(6), the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the sixty-day (60) period immediately preceding the initial Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D; and

(6) In the case of an individual described in Section 365:10-5-129.1(b) but not described in the preceding provisions of this Subsection, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date.

(d) **Extended Medigap access for interrupted trial periods.**

(1) In the case of an individual described in Section 365:10-5-129.1(b)(5) (or deemed to be

so described, pursuant to this paragraph) whose enrollment with an organization or provider described in Section 365:10-5-129.1(b)(5)(A) is involuntarily terminated within the first twelve (12) months or enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(5);

(2) In the case of an individual described in Section 365:10-5-129.1(b)(6) (or deemed to be so described, pursuant to this paragraph) whose enrollment with a plan or in a program described in Section 365:10-5-129.1(b)(6) is involuntarily terminated with the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment described in Section 365:10-5-129.1(b)(6); and

(3) For purposes of Sections 365:10-5-129.1(b)(5) and (b)(6), no enrollment of an individual with an organization or provider described in Section 365:10-5-129.1(b)(5)(a), or with a plan or in a program described in Section 365:10-5-129.1(b)(6), may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

(e) **Products to which eligible persons are entitled.** The Medicare supplement policy to which eligible persons are entitled under:

(1) **Section 365:10-5-129.1(b)(1), (2), (3) and (4).** Section 365:10-5-129.1(b)(1), (2), (3) and (4) is a Medicare supplement policy which has a benefit package classified as Plan A, B,C, F D, G (including F and G with a high deductible), K or L offered by any issuer.

(2) **Section 365:10-5-129.1(b)(5).**

(A) Subject to subparagraph (B), Section 365:10-5-129.1(b)(5) is the same Medicare supplement policy in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in Section 365:10-5-129.1(e)(1).

(B) After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this subparagraph is: The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or at the election of the policyholder, an A, B, C, F D, G (including F or G with a high deductible, K or L policy that is offered by any issuer;

(3) **Section 365:10-5-129.1(b)(6)(A).** Section 365:10-5-129.1(b)(6)(A) shall include any Medicare supplement policy offered by any issuer.

(4) **Section 365:10-5-129.1(b)(7).** Section 365:10-5-129.1(b)(7) is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage .

(5) For individuals who meet any of the conditions identified in subsection (b) and who are under age 65 and enrolled in Medicare due to disability shall be limited to the standardized Medicare supplement plan identified by the issuer as outlined in Section 365:10-5-129 (d). Such individuals would be subject to the timeframe stated under Section 365:10-5-129.1(a)(1). The premium rate charged for such disabled person may not exceed the lowest

available aged premium rate for such plan.

(f) **Notification provisions.**

(1) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual loses coverage or benefits due to the termination of a contract or agreement, policy, or plan, the organization that terminates the contract or agreement, the issuer terminating the policy, or the administrator of the plan being terminated, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement polices under Section 365:10-5-129.1(a). Such notice shall be communicated contemporaneously with the notification of termination.

(2) At the time of an event described in Section 365:10-5-129.1(b) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of his or her rights under this section, and of the obligations of issuers of Medicare supplement policies under Section 365:10-5-129.1(a). Such notice shall be communicated within ten working days of the issuer receiving notification of disenrollment.

**365:10-5-132. Filing and approval of policies and certificates and premium rates**

(a) **Policy forms and certificates filing and approval requirements.** An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed with and approved by the Commissioner in accordance with filing requirements and procedures prescribed by the Commissioner.

(b) **Removal of Prescription Drug benefit.** An issuer shall file any rider or amendments to policy and certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

(c) **Premium rates and rating schedule filing and approval requirements.** An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Commissioner in accordance with the filing requirements and procedures prescribed by the Commissioner.

(d) **Additional policy or certificate forms.**

(1) Except as provided in paragraph (2) of this subsection, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

(2) An issuer may offer, with the approval of the Commissioner, up to four (4) additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(A) The inclusion of new or innovative benefits;

(B) The addition of either direct response or agent marketing methods;

(C) The addition of either guaranteed issue or underwritten coverage;

(D) The offering of coverage to individuals eligible for Medicare by reason of disability.

(3) For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

(e) **Policy forms and certificate forms availability for purchase after Commissioner's approval.**

(1) Except as provided in (A) of this paragraph, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Part that has been approved by the Commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

(A) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Commissioner in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(B) An issuer that discontinues the availability of a policy form or certificate form pursuant to (A) of this paragraph shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Commissioner of the discontinuance. The period of discontinuance may be reduced if the Commissioner determines that a shorter period is appropriate.

(2) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

(3) A change in the rating structure or methodology shall be considered a discontinuance under (d)(1) of this section unless the issuer complies with the following requirements:

(A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The Commissioner may approve a change to the differential which is in the public interest.

(f) **Combination of policy forms or certificate forms experience for purposes of refund or credit calculation.**

(1) Except as provided in (2) of this subsection, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 365:10-5-131.

(2) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(g) **Attained age rating.** An issuer shall not present for filing or approval a rate structure for its Medicare supplement policies or certificates issued after the effective date of the amendment of this regulation based upon a structure or methodology with any groupings of attained ages greater than one year after age 67. The ratio between rates for successive ages shall increase smoothly as age increases. After the age of 90, a rate structure with groupings of attained ages greater than one year is allowed.

**APPENDIX C. RESCISSION REPORTING FORM FOR LONG-TERM CARE POLICIES**

**FOR THE STATE OF _____**
**FOR THE REPORTING YEAR 20[ ]**

Company Name: _____

Address: _____

Phone Number: _____

Due: March 1 annually

Instructions:
The purpose of this form is to report all rescissions of long-term care insurance policies or certificates. Those rescissions voluntarily effectuated by an insured are not required to be included in this report. Please furnish one form per rescission.

| Policy Form # | Policy and Certificate # | Name of Insured | Date of Policy Issuance | Date/s Claim/s Submitted | Date of Rescission |
|---|---|---|---|---|---|
| | | | | | |

Detailed reason for rescission: _____
_____
_____
_____
_____
_____

_____
Signature

_____
Name and Title (please type)

_____
Date

**APPENDIX F. CREDIT INSURANCE**
**DEVIATION REQUEST FORM**

Part A.

NAIC Company Code _____

Company Name _____

Creditor Name _____

This deviation request form must be completed separately for each plan of credit life or credit disability insurance written by the creditor or group of creditors requesting the deviation. Experience of accounts may be combined only within the same plan of benefits and class of business. If experience of accounts is combined, attach a list of those included.

Based on the Experience Period commencing _____ and
(month/day/year)
ending _____.
(month/day/year)

Class of Business:

A. [] Commercial Banks, Savings and Loan Associations, and Mortgage Loan Companies.

B. [] Finance Companies and Small Loan Companies.

C. [] Credit Unions.

D. [] Production Credit Associations (Agricultural and Horticultural P.C.A.'s).

E. [] Dealers (Auto and Truck Dealers, Other Dealers, Retail Stores, Etc.).

F. [] Other than A thru E (Specify_____).

Plan of Benefits: ( ) Credit Life, Death Benefits Only
( ) Credit Disability

_____ days
_____ retro _____ non-retro

Form CI-DRF: Part B - Case Experience.

| | 20___ | 20___ | 20___ | Total |
|---|---|---|---|---|
| 1. Actual Earned Premiums | _____ | _____ | _____ | _____ |
| a. Net Written Premiums* | _____ | _____ | _____ | _____ |
| b. Premium Reserve, Beginning Period | _____ | _____ | _____ | _____ |
| c. Premium Reserve, End of Period | _____ | _____ | _____ | _____ |
| d. Earned Premiums, (a + b - c) | _____ | _____ | _____ | _____ |
| 2. Earned Premiums at Presumptive Rates | _____ | _____ | _____ | _____ |
| 3. Incurred Claims | | | | |
| a. Claims Paid | _____ | _____ | _____ | _____ |
| b. Unreported Claims, Beginning of Period | _____ | _____ | _____ | _____ |
| c. Unreported Claims, End of Period | _____ | _____ | _____ | _____ |
| d. Claim Reserve, Beginning of Period | _____ | _____ | _____ | _____ |
| e. Claim Reserve, End of Period | _____ | _____ | _____ | _____ |
| f. Incurred Claims, (a - b + c - d + e) | _____ | _____ | _____ | _____ |
| 4. Actual Loss Ratio for Case at Presumptive Rates: 3(f) / 2 | _____ | _____ | _____ | _____ |
| 5. Average Number of Life Years** | _____ | _____ | _____ | _____ |
| 6. Incurred Claim Count** | _____ | _____ | _____ | _____ |

* Net written premiums are to be determined as Gross Premium

written (before deductions for dividends and experience rating credits) less refunds on terminations.

** Entries on 5. or 6. should be based on the Credibility Table elected by the insurer.

Form CI-DRF: Part C
Determination of Deviated Presumptive Case Rate

(a) Single Account Cases: If the account is 100% credible or if it is within the definition of a single account case as filed by the insurer, the deviated presumptive case rate for the account will be determined by the appropriate formula set forth in (c) below.

(b) Multiple Account Case: If the account is in a multiple account case, the deviated presumptive case rate for the account will be the case rate for that multiple account case determined by the appropriate formula set forth in (c) below.

(c) Calculation of Deviated Presumptive Case Rates:

(1) Symbols and Definitions:
NCR=New Case Rate
PFR=Presumptive Rate
ALR=Actual Loss Ratio for Case at Presumptive Rate Basis
ELR=Expected Loss Ratio at Presumptive Rate Basis
Z =Credibility Factor for Case
CLR=Credibility Adjusted Case Loss Ratio at Presumptive Basis = Z (ALR) + (1-Z) (ELR)

(2) New Case Rate: Credit Life Insurance

(A) If CLR is greater than ELR, NCR = PFR [1 + 1.1 (CLR - ELR) ]

(B) If CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)]

(3) New Case Rate: Credit Disability Insurance

(A) If CLR is greater than ELR, NCR = PFR [1 + 1.15 (CLR - ELR)]

(B) If CLR is less than ELR, NCR = PFR [1 - (ELR - CLR)]

**APPENDIX H. INVENTORY**
**CREDIT LIFE AND DISABILITY**
**PRESUMPTIVE RATES**

FORM CI-I-PR

NAIC COMPANY CODE: _____

COMPANY NAME: _____

**CLASS OF BUSINESS:** (Check One)

A. [] Commercial Banks, Savings & Loan Associations & Mortgage Loan Companies
B. [] Finance Companies and Small Loan Companies
C. [] Credit Unions
D. [] Production Credit Associations (Agricultural & Horticultural P.C.A.'s)
E. [] Dealers (Auto & Truck Dealers, Other Dealers, Retail Stores, etc.)
F. [] Other than A thru E (Specify: _____)

| **SINGLE LIFE--PLAN OF BENEFITS** | **20____** | **20____** | **20____** |
|---|---|---|---|
| SINGLE PREMIUM: | | | |
| Reducing Term. . . . . | [] | [] | [] |
| Level Term . . . . . | [] | [] | [] |
| OUTSTANDING BALANCE: | | | |
| Revolving Account. . . . . | [] | [] | [] |
| Other Than Revolving Account . . . . . | [] | [] | [] |

| **JOINT LIFE--PLAN OF BENEFITS** | **20____** | **20____** | **20____** |
|---|---|---|---|
| SINGLE PREMIUM: | | | |
| Reducing Term. . . . . | [] | [] | [] |
| Level Term . . . . . | [] | [] | [] |
| OUTSTANDING BALANCE: | | | |
| Revolving Account. . . . . | [] | [] | [] |
| Other Than Revolving Account . . . . . | [] | [] | [] |

| **DISABILITY--PLAN OF BENEFITS** | **20____** | **20____** | **20____** |
|---|---|---|---|
| SINGLE PREMIUM: | | | |
| 7 Day Retro . . . . . | [] | [] | [] |
| 14 Day Retro . . . . . | [] | [] | [] |
| 30 Day Retro . . . . . | [] | [] | [] |

| | | | |
|---|---|---|---|
| 14 Day Non-Retro . . . . . | [] | [] | [] |
| 30 Day Non-Retro . . . . . | [] | [] | [] |
| 90 Day Non-Retro . . . . . | [] | [] | [] |

| **OUTSTANDING BALANCE REVOLVING ACCOUNT** | **20____** | **20____** | **20____** |
|---|---|---|---|
| 7 Day Retro . . . . . | [] | [] | [] |
| 14 Day Retro . . . . . | [] | [] | [] |
| 30 Day Retro . . . . . | [] | [] | [] |
| 14 Day Non-Retro . . . . . | [] | [] | [] |
| 30 Day Non-Retro . . . . . | [] | [] | [] |
| 90 Day Non-Retro . . . . . | [] | [] | [] |

| **OUTSTANDING BALANCE OTHER THAN REVOLVING ACCOUNT** | **20____** | **20____** | **20____** |
|---|---|---|---|
| 7 Day Retro . . . . . | [] | [] | [] |
| 14 Day Retro . . . . . | [] | [] | [] |
| 30 Day Retro . . . . . | [] | [] | [] |
| 14 Day Non-Retro . . . . . | [] | [] | [] |
| 30 Day Non-Retro . . . . . | [] | [] | [] |
| 90 Day Non-Retro . . . . . | [] | [] | [] |

APPENDIX J. CREDIT LIFE INSURANCE EXPERIENCE REPORT

FORM CI-CX-L

STATE OF _____ FOR CALENDAR YEAR _____

NACI COMPANY CODE: _____

COMPANY NAME: _____

CLASS OF BUSINESS: (Check One)

A. [] Commercial Banks, Savings & Loan Associations & Mortgage Loan Companies
B. [] Finance Companies and Small Loan Companies
C. [] Production Credit Associations (Agricultural & Horticultural P.C.A.'s)
D. [] Dealers (Auto & Truck Dealers, Other Dealers, Retail Stores, etc.)
E. [] Other than A thru E (Specify: _____ )

PLAN OF BENEFITS: (Check One Only)

| | Single Lives | Joint Lives |
|---|---|---|
| Single Premium Receiving Term | [] | [] |
| Single Premium Level | [] | [] |
| OUTSTANDING BALANCE: | | |
| Revolving Account (open end) | [] | [] |
| Other Than Revolving Account | [] | [] |

Form CI-DRF: Part B – Case Experience

| | 20__ | 20__ | 20__ | 20__ |
|---|---|---|---|---|
| 1. Actual Earned Premiums* | _____ | _____ | _____ | _____ |
| a. Net Written Premiums* | _____ | _____ | _____ | _____ |
| b. Premium Reserve, Beginning of Period | _____ | _____ | _____ | _____ |
| c. Premium Reserve, End of Period | _____ | _____ | _____ | _____ |
| d. Actual Earned Premiums (a+b-c) | _____ | _____ | _____ | _____ |
| e. Earned Premiums at presumptive rate (Form CI-EP-L) | _____ | _____ | _____ | _____ |

| | | | | |
|---|---|---|---|---|
| 2. Incurred Claims | | | | |
| a. Claims Paid | _____ | _____ | _____ | _____ |
| b. Unreported Claims, Beginning of Period | _____ | _____ | _____ | _____ |
| c. Unreported Claims, End of Period | _____ | _____ | _____ | _____ |
| d. Claim Reserve, Beginning of Period** | _____ | _____ | _____ | _____ |
| e. Claim Reserve, End of Period | _____ | _____ | _____ | _____ |
| f. Incurred Claims, End of Period | _____ | _____ | _____ | _____ |
| 3. Loss Ratios | _____ | _____ | _____ | _____ |
| a. Actual Loss Ratio (2f/1d) | _____ | _____ | _____ | _____ |
| b. Loss Ratio at presumptive rate (2f/1e) | _____ | _____ | _____ | _____ |
| 4. Mean Insurance In Force* | _____ | _____ | _____ | _____ |
| 5. Losses Per $100 Mean Insurance In Force (100x2f) / Item 4 | _____ | _____ | _____ | _____ |
| 6/ Losses Per $100 Initial Amount On Basis of 12 Month Policy (13) / (24) x Item 5*** | _____ | _____ | _____ | _____ |

*See instructions.

**Must take into account reported claims due but unpaid.

***To be completed for reducing term insurance only.

NOTE: Mean Insurance In Force shall be used in arriving at the statewide loss ratios for purposes of developing presumptive premium rates.

**APPENDIX K. CREDIT DISABILITY INSURANCE EXPERIENCE REPORT**

FORM CI-EX-DIS

STATE OF _____ FOR CALENDAR YEAR _____

NAIC COMPANY CODE: _____

COMPANY NAME: _____

**CLASS OF BUSINESS:** (Check One)

A. [] Commercial Banks, Savings & Loan Associations & Mortgage Loan Companies
B. [] Finance Companies and Small Loan Companies
C. [] Credit Unions
D. [] Production Credit Associations (Agricultural & Horticultural P.C.A.'s)
E. [] Dealers (Auto & Truck Dealers, Other Dealers, Retail Stores, etc.)
F. [] Other than A thru E (Specify: _____)

**PLAN OF BENEFITS:** (Check One Only)

[] SINGLE PREMIUM [] OUTSTANDING BALANCE
[] 7 Day Retro. [] 7 Day Retro. [] 30 Day Non-Retro.
[] 14 Day Retro. [] 14 Day Non-Retro. [] 90 Day Non-Retro.
[] Revolving Account (open-end) Indebtedness
[] Other Than Revolving Account Indebtedness

| | 20___ | 20___ | 20___ | Total |
|---|---|---|---|---|
| **1. Actual Earned Premiums** | | | | |
| a. Net Written Premiums* | _____ | _____ | _____ | _____ |
| b. Premium Reserve, Beginning Period | _____ | _____ | _____ | _____ |
| c. Premium Reserve, End of Period | _____ | _____ | _____ | _____ |
| d. Actual Earned Premiums (a+b-c) | _____ | _____ | _____ | _____ |
| e. Earned Premiums at | | | | |

| | | | | |
|---|---|---|---|---|
| Presumptive Rate (Form CI-EP-DIS) | _____ | _____ | _____ | _____ |
| **2. Incurred Claims** | | | | |
| a. Claims Paid | _____ | _____ | _____ | _____ |
| b. Unreported Claims, Beginning of Period** | _____ | _____ | _____ | _____ |
| c. Unreported Claims, End of Period** | _____ | _____ | _____ | _____ |
| d. Claim Reserve, Beginning of Period*** | _____ | _____ | _____ | _____ |
| e. Claim Reserve, End of Period*** | _____ | _____ | _____ | _____ |
| f. Incurred Claims (a-b+c-d+e) | _____ | _____ | _____ | _____ |
| **3. Loss Ratios** | | | | |
| a. Actual Loss Ratio (2f/1d) | _____ | _____ | _____ | _____ |
| b. Loss Ratio at presumptive rate (2f/1e) | _____ | _____ | _____ | _____ |

* See instructions.

** Must take into account unreported claims due but unpaid and pending but not due.

*** Must take into account reported claims due but unpaid and pending but not due.

**APPENDIX M. CREDIT DISABILITY INSURANCE EXPERIENCE REPORT**

STATE OF _____
PRESUMPTIVE EARNED PREMIUM

FORM CI-EP-DIS

Class of Business_____ Calendar Year 20____

Premium Mode_____ Plan of Benefits_____

| | Actual Earned Premium Col. 1 | Premium Rates: 12 Mo. Col. 2 | 24 Mo. Col. 3 | 36 Mo. Col. 4 | Pre-sumptive Earned Premium Col. 5 |
|---|---|---|---|---|---|
| A. Earned Premium at Presumptive Rate | _____ | _____ | _____ | _____ | _____ |
| B. Other Premium at Other Than Presumptive Rate: | | | | | |
| 1. | | | | | |
| a. Actual Rate | XXXX | _____ | _____ | _____ | XXXX |
| b. Ratio | XXXX | _____ | _____ | _____ | XXXX |
| c. Earned Premium | _____ | _____ | _____ | _____ | _____ |
| 2. | | | | | |
| a. Actual Rate | XXXX | _____ | _____ | _____ | XXXX |
| b. Ratio | XXXX | _____ | _____ | _____ | XXXX |
| c. Earned Premium | _____ | _____ | _____ | _____ | _____ |
| 3. | | | | | |
| a. Actual Rate | XXXX | _____ | _____ | _____ | XXXX |
| b. Ratio | XXXX | _____ | _____ | _____ | XXXX |
| c. Earned Premium | _____ | _____ | _____ | _____ | _____ |
| Totals | _____ | XXXX | XXXX | XXXX | _____ |
| | **To Form CI-EX-DIS Line 1d.** | | | | **To Form CI-EX-DIS Line 1e.** |

**APPENDIX N. CREDIT LIFE INSURANCE**
**EXPERIENCE RECONCILIATION TO STATE PAGE**

STATE OF _____
FOR THE CURRENT YEAR 20____

FORM CI-R-L

| | Premiums | | Claims | |
|---|---|---|---|---|
| **Credit Life:** | Written (Line 1a) | Earned (Line 1d) | Paid (Line 2a) | Incurred (Line 2f) |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Total Life | | | | |
| Annual Statement Page 46, Lines 4, 19, & 21 | _____ | _____ | _____ | _____ |

Explain any differences between "Total Life" and corresponding amounts on page 46 (Line 4, Col. 2, Line 19, Col. 2, and Line 21, Col. 2).

Note that "Total Life" amount for Earned Premiums is not reported on page 46 of the Texas Annual Statement.

**APPENDIX O. CREDIT DISABILITY INSURANCE**
**EXPERIENCE RECONCILIATION TO STATE PAGE**

STATE OF _____
FOR THE CURRENT YEAR 20____

FORM CI-R-DIS

| | Premiums | | Claims | |
|---|---|---|---|---|
| **Credit Disability:** | Written (Line 1a) | Earned (Line 1d) | Paid (Line 2a) | Incurred (Line 2f) |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Page _____ of _____ | _____ | _____ | _____ | _____ |
| Total Life | | | | |
| Annual Statement Page 46, Line 29 | _____ | _____ | _____ | _____ |

Explain any differences between "Total Disability" and corresponding amounts on page 46 (Line 29, Cols. 1, 2, 3, 4 and 5).

# APPENDIX QQ. EXTERNAL REVIEW REQUEST FORM

This **EXTERNAL REVIEW REQUEST FORM** must be filed with the Oklahoma Insurance Department within **FOUR (4) MONTHS** after receipt from your insurer of a denial of payment on a claim or request for a health care service or treatment.

**EXTERNAL REVIEW REQUEST FORM**

**APPLICANT NAME** _____

Please Check One: ☐ Covered person/Patient ☐ Authorized Representative

**COVERED PERSON/PATIENT INFORMATION**

Covered Person Name: _____

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Covered Person Phone #: Home (_____)_____ Work (_____)_____

**INSURANCE INFORMATION**

Insurer/HMO Name: _____

Covered Person Insurance ID#: _____

Insurance Claim/Reference #: _____

Insurer/HMO Mailing Address: _____

City: _____ State: _____ Zip: _____

Insurer Telephone #: (_____)_____

**EMPLOYER INFORMATION**

Employer's Name: _____

Employer's Phone #: (_____)_____

Is the insurance you have through your employer a self-funded plan? _____. If you are not certain please check with your employer. Most self-funded plans are not eligible for external review. However, some self-funded plans may voluntarily provide external review, but may have different procedures. You should check with your employer.

**HEALTH CARE PROVIDER INFORMATION**

Treating Physician/Health Care Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: (_____)_____

Medical Record #: _____

**REASON FOR HEALTH CARRIER DENIAL** (Please check one)*

☐ The health care service or treatment is not medically necessary.

☐ The health care service or treatment is experimental or investigational.

*You can describe in your own words the health care service or treatment in dispute using the attached pages below.

**EXPEDITED REVIEW**

**If you need a fast decision**, you may request that your external appeal be handled on an expedited basis. To complete this request, your treating health care provider must fill out the attached form stating that a delay would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function. Is this a request for an expedited appeal? ☐ Yes ☐ No

**SIGNATURE AND RELEASE OF MEDICAL RECORDS**

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I, _____, hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize by insurance company and my health care providers to release all relevant medical or treatment records to the independent review organization and the Oklahoma Insurance Department. I understand that the independent review organization and the Oklahoma Insurance Department will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other – Please Specify)

**APPOINTMENT OF AUTHORIZED REPRESENTATIVE**

**(Fill out this section only if someone else will be representing you in this appeal.)**

You can represent yourself, or you may ask another person, including your treating health care provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____ _____

Signature of Covered Person (or legal representative)* Date

*(Parent, Guardian, Conservator or Other—Please Specify)

Address of Authorized Representative: _____

City: _____ State: _____ Zip: _____

Phone #: Daytime (_____)_____ Evening (_____)_____

**HEALTH CARE SERVICE OR TREATMENT DECISION IN DISPUTE**

DESCRIBE IN YOUR OWN WORDS THE DISAGREEMENT WITH YOUR HEALTH CARRIER. INDICATE CLEARLY THE SERVICE(S) BEING DENIED AND THE SPECIFIC DATE(S) BEING DENIED. EXPLAIN WHY YOU DISAGREE. ATTACH ADDITIONAL PAGES IF NECESSARY AND INCLUDE PERTINENT MEDICAL RECORDS, IF AVAILABLE. YOU MUST ALSO ATTACH ANY INFORMATION YOU RECEIVED FROM YOUR HEALTH CARRIER CONCERNING THE DENIAL, AND ANY ADDITIONAL INFORMATION FROM YOUR PHYSICIAN/HEALTH CARE PROVIDER THAT YOU WANT THE INDEPENDENT REVIEW ORGANIZATION REVIEWER TO CONSIDER.

**WHAT TO SEND AND WHERE TO SEND IT**

**PLEASE CHECK BELOW (NOTE: YOUR REQUEST WILL NOT BE ACCEPTED FOR FULL REVIEW UNLESS ALL FOUR (4) ITEMS BELOW ARE INCLUDED*)**

1. ☐ **YES**, I have included this completed application form signed and dated.

2. ☐ **YES**, I have included a photocopy of my insurance identification card or other evidence showing that I am insured by the health insurance company named in this application;

3. ☐ **YES****, I have enclosed the letter from my health carrier or utilization review company that states:
   (a) Their decision is final and that I have exhausted all internal review procedures; or
   (b) They have waived the requirement to exhaust all of the health carrier's internal review procedures.

**You may make a request for external review without exhausting all internal review procedures under certain circumstances. You should contact the Oklahoma Insurance Department for more information.

4. ☐ **YES**, I have included a copy of my certificate of coverage or my insurance policy benefit booklet, which lists the benefits under my health benefit plan.

*Call the Oklahoma Insurance Department at 800-522-0071 or 405-521-2828 if you need help in completing this application or if you do not have one or more of the above items and would like information on alternative ways to complete your request for external review.

If you are requesting a standard external review, send all paperwork to:

Oklahoma Insurance Department
External Review
400 N.E. 50th
Oklahoma City, Oklahoma 73105

**If you are requesting an expedited external review, call the Insurance Department at 800-522-0071 or 405-521-2828 before sending your paperwork, and you will receive instructions on the quickest way to submit the application and supporting information.**

**CERTIFICATION OF TREATING HEALTH CARE PROVIDER**
**FOR EXPEDITED CONSIDERATION OF A PATIENT'S EXTERNAL REVIEW APPEAL**

## NOTE TO THE TREATING HEALTH CARE PROVIDER

Patients can request an external review when a health carrier has denied a health care service or course of treatment on the basis of a utilization review determination that the requested health care service or course of treatment does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. The Oklahoma Insurance Department oversees external appeals. The standard external review process can take up to 45 days from the date the patient's request for external review is received by our department. Expedited external review is available only if the patient's treating health care provider certifies that adherence to the time frame for the standard external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. An expedited external review must be completed at most within 72 hours. This form is for the purpose of providing the certification necessary to trigger expedited review.

## GENERAL INFORMATION

Name of Treating Health Care Provider: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone #: (_____)_____ Fax #: (_____)_____

Licensure and Area of Clinical Specialty: _____

Name of Patient: _____

Patient's Insurer Member ID#: _____

**CERTIFICATION**

I hereby certify that: I am a treating health care provider for _____
(hereafter referred to as 'the patient'); that adherence to the time frame for conducting a standard external review of the patient's appeal would, in my professional judgment, seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function; and that, for this reason, the patient's appeal of the denial by the patient's health carrier of the requested health care service or course of treatment should be processed on an expedited basis.

_____
Treating Health Care Provider's Name (Please Print)

_____ _____
Signature Date

**PHYSICIAN CERTIFICATION**
**EXPERIMENTAL/INVESTIGATIONAL DENIALS**
**(To Be Completed by Treating Physician)**

I hereby certify that I am the treating physician for _____
(covered person's name) and that I have requested the authorization for a drug, device, procedure or therapy denied for coverage due to the insurance company's determination that the proposed therapy is experimental and/or investigational. I understand that in order for the covered person to obtain the right to an external review of this denial, as treating physician I must certify that the covered person's medical condition meets certain requirements:

**In my medical opinion as the Insured's treating physician, I hereby certify to the following:**
**(Please check all that apply)** (**NOTE:** Requirements #1 - #3 below must all apply for the covered person to qualify for an external review).

| | | |
|---|---|---|
| 1) ☐ | The covered person has a terminal medical condition, or a life threatening condition, or a seriously debilitating condition. | |
| 2) ☐ | The covered person has a condition that qualifies under one or more of the following:<br>[please indicate which description(s) apply]: | |
| | i. ☐ | Standard health care services or treatments have not been effective in improving the covered person's condition; |
| | ii. ☐ | Standard health care services or treatments are not medically appropriate for the covered person; or |
| | iii. ☐ | There is no available standard health care service or treatment covered by the health carrier that is more beneficial than the requested or recommended health care service or treatment. |
| 3) ☐ | The health care service or treatment I have recommended and which has been denied, in my medical opinion, is likely to be more beneficial to the covered person than any available standard health care services or treatments. | |
| 4) ☐ | The health care service or treatment I have recommended would significantly less effective if not promptly initiated.<br><br>Explain: _____<br><br>_____ | |
| 5) ☐ | It is my medical opinion based on scientifically valid studies using accepted protocols that the health care service or treatment requested by the covered person and which has been denied is likely to be more beneficial to the covered person than any available standard health care services or treatments.<br><br>Explain: _____<br><br>_____ | |

Please provide a description of the recommended or requested health care service or treatment that is the subject of the denial. (Attach additional sheets as necessary.)

Physician's Name (Please Print)

Physician's Signature

Date

## APPENDIX RR. APPLICATION FOR REGISTRATION AS AN INDEPENDENT REVIEW ORGANIZATION

Oklahoma Insurance Department
400 N.E. 50th
Oklahoma City, Oklahoma 73105
405-521-2828

**Application for Registration as an Independent Review Organization**

Type of Entity: ☐ Corporation ☐ Partnership ☐ LLC ☐ Other _____

Contact Information for Application

| Legal Name of Applicant | State of Domicile | Federal EIN | |
|---|---|---|---|
| Contact Person (Name and Title) | Phone<br>(  ) | Email | |
| Business Address (Do not use PO Box) | City | State | Zip |
| Mailing Address (if different from business address) | City | State | Zip |

Contact Information for Initiating External Reviews (also to be made available to carriers and consumers)

| Contact Person (Name and Title) or Department | | Phone<br>(  ) | Email | |
|---|---|---|---|---|
| Mailing Address | | City | State | Zip |
| Website | Toll-Free Telephone Number | | Fax<br>(  ) | |
| Other Contact Information | | | | |

A

**Applicant Attestation and Certification**

Applicant certifies that it will notify the Oklahoma Insurance Department immediately if its accreditation is lost with the American Accreditation Healthcare Commission/URAC. Applicant acknowledges that the Oklahoma Insurance Department may terminate this license if the applicant loses accreditation or no longer satisfies the minimum requirements for licensure.

Applicant acknowledges that payment of any fees associated with any external reviews conducted pursuant to 36 O.S. § 6475.1 et seq. are the sole responsibility of the health carrier whose medical decision is being reviewed. Applicant understands that it has no recourse against the Oklahoma Insurance Department or the state of Oklahoma to the extent that any health carrier fails to pay any medical reviewer fees. Applicant authorizes the Oklahoma Insurance Department to verify information with any federal, state, or local government agency, insurance company or accrediting organization.

Applicant acknowledges and represents that it understands and will comply with Oklahoma's insurance laws and the rules of the Oklahoma Insurance Department. Applicant hereby represents that it will comply with all requirements imposed under 36 O.S. § 6475.1 et seq. and assures that no conflict of interest or improper controlling interest as outlined in the statute exists. Applicant further agrees to maintain and provide to the Oklahoma Insurance Department the information set out in 36 O.S. § 6475.15.

I certify that, under penalty of perjury, I am the person named herein and know the contents thereof, and that all of the information submitted in this application and its attachments is true and complete. I attest that I have the authority and capacity to execute this certification on behalf of the applicant. I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license denial or revocation and may subject me to civil or criminal penalties.

| | |
|---|---|
| Signature of person who completed application | Signature of Officer, Director, or Board Member |
| Printed Name | Printed Name |
| Title | Title |
| Date | Date |

Please provide the following as separate attachments:

1. A narrative description and an organizational chart to provide an overview of the applicant's operations.
2. A list of names and official capacities of all persons responsible for the applicant's external review program, including:
    a. all members of the governing body, the officers and directors of a corporation, and the partners or associates of a partnership or association; and,
    b. disclosure of any contracts or arrangements between those persons and the applicant, including any appearance of a conflict of interest as specified in 36 O.S. 6475.13.
3. A written statement addressing the determination of any conflicts of interest involving the applicant and all clinical reviewers.
4. A copy of your most recent certificate from American Accreditation HealthCare Commission/URAC for Independent Review Organizations.
5. A list of specific areas of clinical expertise in which you conduct independent reviews, if applicable.
6. A schedule of fees.
7. A copy of your current Certificate of Authority provided by the Oklahoma Secretary of State.
8. A narrative description of the quality assurance mechanism in place to meet the requirements of 36 O.S. 6475.13(A)(1).
9. A narrative description of the process utilized to maintain the confidentiality of personally identifiable health information and of clinical reviewers' and contract specialists' identities.
10. A copy of the policy and procedures that govern all aspects of the external review process for both standard and expedited reviews, including experimental and investigational treatments.

Please submit this application and all required attachments to:

Oklahoma Insurance Department
External Review Program
400 N.E. 50th
Oklahoma City, OK 73105

# APPENDIX SS. INDEPENDENT REVIEW ORGANIZATION EXTERNAL REVIEW ANNUAL REPORT FORM

**Oklahoma Insurance Department**

**Independent Review Organization External Review Annual Report Form**

| | | | |
|---|---|---|---|
| External Review Annual Summary for 20_____ | | Due by January 31 for the previous calendar year. | |
| Each independent review organization (IRO) shall submit an annual report with information for each health carrier in the aggregate on external reviews performed in Oklahoma only. | | | |
| 1. IRO name: | | Filing date: | |
| 2. IRO license/certification no: | | | |
| 3. IRO address: | | | |
| City, State, Zip: | | | |
| 4. IRO Website: | | | |
| 5. Name of person completing this form: | | | |
| Email: | Phone: | Fax: | |
| 6. Person responsible for regulatory compliance and quality of external reviews: | | | |
| Name: | Title: | | |
| 7. Total number of requests for external review received from the Oklahoma Insurance Department during the reporting period: | | | |
| 8. Number of standard external reviews: | | | |
| 9. Average number of days IRO required to reach a final decision in standard reviews: | | | |
| 10. Number of expedited reviews completed to a final decision: | | | |
| 11. Average number of days IRO required to reach a final decision in expedited reviews: | | | |
| 12. Number of medical necessity reviews decided in favor of the health carrier: | | | |
| Briefly list procedures denied: | | | |

| | | | |
|---|---|---|---|
| 13. Number of medical necessity reviews decided in favor of the covered person: | | | |
| Briefly list procedures approved: | | | |
| 14. Number of experimental/investigational reviews decided in favor of the health carrier: | | | |
| Briefly list procedures denied: | | | |
| 15. Number of experimental/investigational reviews decided in favor of the covered person: | | | |
| Briefly list procedures approved: | | | |
| 16. Number of reviews terminated as the result of a reconsideration by the health carrier: | | | |
| 17. Number of reviews terminated by the covered person: | | | |
| 18. Number of reviews declined due to possible conflict with | health carrier: | | |
| | covered person: | | |
| | health care provider: | | |
| Describe possible conflicts of interest: | | | |
| 19. Number of reviews declined due to other reasons not reflected in #18 above: | | | |
| Briefly list these reasons: | | | |

Please submit to:
Oklahoma Insurance Department
400 N.E. 50th
Oklahoma City, OK 73105

## APPENDIX TT. HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM

**Oklahoma Insurance Department**

**Health Carrier External Review Annual Report Form**

| | | | |
|---|---|---|---|
| External Review Annual Summary for 20_____ | | Due by January 31 for the previous calendar year. | |
| Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan. | | | |
| 1. Health carrier name: | | Filing date: | |
| 2. Health carrier address: | | | |
| City, State, Zip: | | | |
| 3. Health carrier Website: | | | |
| 4. Name of person completing this form: | | | |
| Email: | Phone: | Fax: | |
| 5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period: | | | |
| 6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review: | | | |

Please submit to:
Oklahoma Insurance Department
400 N.E. 50th
Oklahoma City, Oklahoma 73105