*Note: A – Property and Casualty Company
B – Life, Accident and Health Company
G – Health Care Centers

HEALTH REINSURANCE ASSOCIATION (CT) &
CONNECTICUT SMALL EMPLOYER HEALTH REINSURANCE POOL
Request for CT Assessment Base 2017

Full Company Name: ______________________________

NAIC Company Code: ______________________________

***Type of Company:** ______________________________

If the information includes figures for affiliates and/or subsidiaries, please list names:

(PLEASE ATTACH A COPY OF A DOCUMENT(S) SUPPORTING REPORTED DIRECT EARNED PREMIUMS)

****

The **basis of assessment** for members of the **Health Reinsurance Association of Connecticut is set forth in the HRA Plan of Operation**. The **basis of assessment** for members of the **Connecticut Small Employer Health Reinsurance Program is set forth in the CSEHRP Plan of Operation**. The Health premiums referred to therein for CONNECTICUT COVERAGE shall correspond to those which are contained in the most recently completed National Association of Insurance Commissioners Annual Statement blank (Calendar Year 2017) as follows:

	HRA (ALL Health Direct Premiums Earned)	**CSEHRP** (ONLY Small Employer Premiums Earned)
i) TOTAL HEALTH INSURANCE DIRECT PREMIUMS EARNED	____________	____________
ii) **Exclusions** (per Sec. 38a-551(a) and 38a-564(7)):		
1) Accident only policies or/and contracts	____________	____________
2) Credit & Vision policies or/and contracts	____________	____________
3) Dental policies or/and contracts	____________	____________
4) Medicare Supplement policies or/and contracts	____________	____________
5) Long-Term Care policies or/and contracts	____________	____________
6) Disability policies or/and contracts	____________	____________
7) Hospital Indemnity policies or/and contracts	____________	____________
8) Workers' Compensation policies or similar law	____________	____________
9) Automobile Medical-Payments Insurance, No-Fault which is statutorily required or equivalent self-insurance	____________	____________
10) Supplement to liability insurance policies or/and contracts	____________	____________
11) Specified disease or limited benefit health insurance policies or/and contracts	____________	____________
Total Exclusions	____________	____________
iii) Total Assessment Base (i) – (ii)	____________	____________

HEALTH REINSURANCE ASSOCIATION (CT) &
CONNECTICUT SMALL EMPLOYER HEALTH REINSURANCE POOL
Request for CT Assessment Base 2017
(Page 2)

II. Request for Updated Information

Full Company Name: ______________________________

NAIC Company Code: ______________________________

Location: ______________________________
(Street and Number) (City) (State & Zip Code)

Mailing (if applicable): ______________________________

Person to Contact: ______________________________

Telephone Number: ______________________________

Facsimile and/or Telex Number: ______________________________

Email: ______________________________

☐ **Check here if your mailing address has changed. Please note any corrections below.**

____

____

III. Certification of Information:

I, the undersigned, an officer of the Company reporting herein, do hereby certify that the information submitted is true and complete to the best of my knowledge and belief.

____
Name of Member Company

____
Signature of Authorized Officer

____
Typed Name of Officer

____
Title of Officer

____
Date

Please submit this form (all 2 pages), using one of the methods below:

1. Email to cwolf@pooladmin.com
2. Fax to (860) 513-4910
3. Mail your reply to:

Health Reinsurance Association
& CT Small Employer Health
Reinsurance Pool
c/o Pool Administrators Inc.
628 Hebron Avenue, Suite 502
Glastonbury, CT 06033