

*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 2016**

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 2016) as follows:

	<u>HRA</u> (ALL Health Direct Premiums Earned)	<u>CSEHRP</u> (ONLY Small Employer Premiums Earned)
i) TOTAL HEALTH INSURANCE DIRECT PREMIUMS EARNED	_____	_____
ii) <u>Exclusions</u> (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)	_____	_____

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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 100
Glastonbury, CT 06033**