PREMIUM COMPILATION FORM

**Company Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAIC:\_\_\_\_\_\_\_\_\_\_**

**Total 2024 Health Care Premiums Written: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Less premiums written for the following types of policies:**

Accident Only $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Disability Income $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospital Indemnity $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Injury $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Long-Term Care $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Specified Disease $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Student Comprehensive Health $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Vision Only $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stop Loss $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other limited benefit not listed below\*

(Please specify)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tax-Exempt Federal Plans, if included in “Total 2024 Health Care Premiums Written”

(Please specify FEHBP, Medicare Part C, Medicare Part D, TRICARE, etc.)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Total Adjustments** $**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Total 2024 Adjusted Health Care Premiums Written** $**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list the types and amounts of coverage included in the “Total 2024 Adjusted Health Care Premiums Written”.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

*Authorized Signature Date*

\*Dental, Medicare Supplemental, Medicaid Capitation or any other supplemental comprehensive coverage policies (including CHAMPUS) are not considered to be limited benefit health care policies and are not to be deducted from the Total Health Care Premiums Written.

Contact Address Update Form

**Company Name:**

**NAIC:**

**Contact Type: Premium Compilation**

To ensure that future notices are sent to the appropriate person, please provide the following contact information, and return via **e-mail to Laurie.Smith@maine.gov**. Thank you.

|  |  |
| --- | --- |
| First Name |  |
| Last Name |  |
| Job Title or Position |  |
| Telephone (incl. area code) |  |
| E-mail Address |  |