

**SURVEY FOR IOWA COMPREHENSIVE HEALTH ASSOCIATION  
for the Year Ending: December 31, 2008**

**INSTRUCTIONS:**

Pursuant to Chapter 514E Iowa Statutes, net losses of the Iowa Comprehensive Health Association shall be assessed to members, in order that the assessment may be made on an equitable basis, you are required to report the following supplemental form and return it to the address listed below by March 15, 2009, even if your company had no premium to report for the calendar year indicated.

**COMPANY INFORMATION:**

Please complete the following:

NAIC# \_\_\_\_\_

Company Name \_\_\_\_\_

Contact Address \_\_\_\_\_

Contact Person \_\_\_\_\_

Contact Phone \_\_\_\_\_

Contact Email Address \_\_\_\_\_

Billing Address (if different) \_\_\_\_\_

Billing Contact Name \_\_\_\_\_

Billing Contact Phone \_\_\_\_\_

Billing Email Address \_\_\_\_\_

**PREMIUM INFORMATION:**

Indicate **NONE** in any section that does not apply to your organization.

**A copy of one of the following Iowa state pages from your annual statement must be returned with this survey.**

- Life Companies: page 24, column 2, line 26
- P&C Companies: page 19, column 2, lines 13-15.7
- Health: page 290, column 1, line 15

Total **Direct Premiums Earned or Subscriber Charges** for the state of IOWA from 2008 Annual Statement \$ \_\_\_\_\_

Less the following deductions **only if included** in the premiums earned above:

- Coverage only for a specified disease or illness \_\_\_\_\_
- Medicare Cost Reimbursement (HMO) \_\_\_\_\_
- Medicare Risk \_\_\_\_\_
- Medicare Part D \_\_\_\_\_
- Medicare Supplement \_\_\_\_\_
- Federal Employee Health Benefit Plan \_\_\_\_\_
- HMO dues from outside Iowa \_\_\_\_\_
- Coverage issued as a supplement to liability insurance \_\_\_\_\_
- Worker's compensation or similar insurance \_\_\_\_\_
- Accident only or disability income insurance \_\_\_\_\_
- A short term limited duration insurance policy \_\_\_\_\_
- Automobile/Homeowner medical payment insurance \_\_\_\_\_
- Credit only insurance \_\_\_\_\_
- Limited scope dental and vision issued under a separate policy \_\_\_\_\_
- Benefits for long term care, nursing home care, home health care  
or community based care issued under a separate policy \_\_\_\_\_
- Hospital Indemnity and fixed indemnity insurance \_\_\_\_\_
- Liability insurance, including general liability and auto liability \_\_\_\_\_
- Medicaid \_\_\_\_\_
- Hawk-I \_\_\_\_\_

Total Deductions \$ \_\_\_\_\_

2008 ICHA Assessment Base \$ \_\_\_\_\_

**SIGNATURE OF OFFICER:**

**I affirm under the penalties for perjury, the above figures are true and correct according to the best of my information, knowledge and belief. I understand that adjustments to these figures will not be allowed.**

Signature of Officer: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

**PREPARATION QUESTIONS:** phone: (800) 290-1368 ext. 1011  
email: cremmert@bmikansas.com

fax: (620) 792-0535

**MAILING ADDRESS:** Iowa Comprehensive Health Association  
Attn: Assessment & Survey Division  
PO Box 1090, Great Bend, KS 67530