

SURVEY FOR IOWA COMPREHENSIVE HEALTH ASSOCIATION

For the Year Ending: December 31, 2009

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, 2010, 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 29, column 1, line 15

Total **Direct Premiums Earned or Subscriber Charges** for the state of IOWA from 2009 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 \$ _____

2009 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. 1044
email: bjamieson@bmikansas.com

fax: (620) 792-0535

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