STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Public Health Fee Assessment Request

For Number of Insured or Enrolled Lives in CT as of May 1st, 2024

Per Conn. Gen. Stat. Sec. 19a-7p

Report Due Date: September 1st, 2024

I. FILLING AS:

- ☐ Domestic Insurer
- ☐ Health Center

II. REPORTING ENTITY:

Company Name:

Street Address:

City, State, Zip:

Contact Person:

Phone:

E-Mail:

Note: All letters and email will be sent to this address. Email should be address used for assessment invoices.

III. NUMBER OF INSURED OR ENROLLED LIVES IN CT:

Report Number: ***If none, please report as "NONE"*** _____

Not later than September 1st annually, each such insurer and health care center shall report to the Insurance Commissioner... the number of insured or enrolled lives in this state as of the preceding May 1st, for which such insurer or health care center is providing health insurance coverage of the types specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469. Do not include lives enrolled in Medicare, any medical assistance program administered by the Department of Social Services, workers compensation insurance or Medicare Part C plans. (Conn. Gen. Stats. Sec. 19a-7p).

IV. CERTIFICATION:

The undersigned hereby certifies (a) that he or she duly executed this report on the date shown below on behalf of the company named above as the Reporting Entity; (b) that he or she is an officer or representative of such company and is authorized to make this certification; and (c) that the facts set forth in this Report are true and correct to the best of his/her knowledge, information and belief.

BY _____ _____
(signature) (print date)

_____ _____
(print name) (Title)

Note: Any insurer or health care center that fails to file this report by the due date shall pay a late filing fee for each day from the date such report was due. Also, If the Insurance Commissioner determines that there is other than a good faith discrepancy between the actual number of insured or enrolled lives that should have been reported and the number actually reported, such insurer or health care center shall pay a civil penalty for each report filed for which the Insurance Commissioner determines there is such a discrepancy. (Conn. Public Act No.15-5).

V. DIRECTIONS/INFORMATION:

Original ink signature not required. Emailed copy is the preferred reporting method.

Electronic Filings:	Electronic filings are **preferred;** sent to cid.phfa@ct.gov
Mailing Address:	Connecticut Insurance Department Attn: Business Office P.O. Box 816 Hartford, CT 06142-0816
Inquiries / Questions?	Please send all inquiries to cid.phfa@ct.gov