Supplemental Health Care Exhibit (SHCE) Waiver Instructions

Pursuant to the Annual Statement instructions, a Company can request a waiver for filing the SHCE. In order to request a waiver, the company must meet the following requirements.

1. The Company must be domiciled in Indiana.

2. The number of "life years" nationally should not exceed 1,000 lives for columns 1 – 9. individually. The MLR interim and final rules adopt the NAIC definition of life-years as the number of member months divided by 12 if based on a full year of reporting.

3. The company is not writing any new major medical health business in Indiana.

4. The company has only closed blocks of business that qualify for columns 1 – 9.

5. The company must complete the attached waiver application and provide the requested information.

6. The completed waiver application is due February 8th.

The completed form should be mailed to:

Roy Eft, Chief Financial Examiner
Indiana Department of Insurance
311 W. Washington St., Suite 300
Indianapolis, IN 46204-2787

Supplemental Health Care Exhibit Waiver Request

Company Name _____NAIC CoCode _____NAIC Group Code _____

_____ ("Company") applies for a waiver from the requirement to file the Supplemental Health Care Exhibit for calendar year _____ and hereby attests that:

1. The Company does not currently have any policies for sale in any state that would meet the definition of individual, small group or large group comprehensive major medical health insurance, mini-med plans (including TRICARE) or expatriate plans.

2. The Company has only closed blocks of major medical health insurance as described above.

3. For Part 1, Columns 1 – 9 please provide the following information for each column on a national basis.

	Comprehensive Health Coverage		
	(1) Individual	(2) Small Group	(3) Large Group
Number of policies in force			
Number of lives			
Number of member months			
Total earned premium			
Total incurred claims			

	Mini Med Plans			
	(1) Individual	(2) Small Group	(3) Large Group	(7) Expatriate
Number of policies in force				
Number of lives				
Number of member months				
Total earned premium				
Total incurred claims				

4. The Company does not intend to sell any policies that meet the definition of individual, small group or large group comprehensive major medical health insurance for calendar year _____.

I hereby certify that the above information is true and accurate to the best of my knowledge and belief.

_____

Signature Date

_____

Name Title

_____

Telephone Email