HSC/HMO ENTITIES

COMPANY NAME: _____ **NAIC Company Code:** _____

Contact: _____ **Telephone:** _____

REQUIRED FILINGS IN THE STATE OF: **Montana** **Filings Made During the Year 2025**

(1) Checklist	(2) Line #	(3) REQUIRED FILINGS FOR THE ABOVE STATE	(4) NUMBER OF COPIES* Domestic State	Domestic NAIC	Foreign State	(5) DUE DATE	(6) FORM SOURCE **	(7) APPLICABLE NOTES
		I. NAIC FINANCIAL STATEMENTS						
☐	1	Annual Statement (8 ½"X14")	1	EO	xxx	3/1	NAIC	
☐	1.1	Printed Investment Schedule detail (Pages E01-E29)	1	EO	xxx	3/1	NAIC	
☐	2	Quarterly Financial Statement (8 ½" x 14")	1	EO	xxx	5/15, 8/15, 11/15	NAIC	
		II. NAIC SUPPLEMENTS						
☐	11	Accident & Health Policy Experience Exhibit	1	EO	xxx	4/1	NAIC	
☐	12	Actuarial Opinion	1	EO	xxx	3/1	Company	
☐	13	Life Supplemental Data due March 1	1	EO	xxx	3/1	NAIC	
☐	14	Life Supplemental Data due April 1	1	EO	xxx	4/1	NAIC	
☐	15	Life Supp Statement non-guaranteed elements–Exh 5, Int. #3	1	EO	xxx	3/1	Company	
☐	16	Life Supp Statement on par/non-par policies–Exh 5 Int. 1&2	1	EO	xxx	3/1	Company	
☐	17	Life, Health & Annuity Guaranty Association Assessable Premium Exhibit, Parts 1 and 2	1	EO	xxx	4/1	NAIC	
☐	18	Long-Term Care Experience Reporting Forms	1	EO	xxx	4/1	NAIC	
☐	19	Management Discussion & Analysis	1	EO	xxx	4/1	Company	
☐	20	Market Conduct Annual Statement Premium Exhibit for Year	1	EO	xxx	3/1	NAIC	
☐	21	Medicare Part D Coverage Supplement	1	EO	xxx	3/1, 5/15, 8/15,11/15	NAIC	
☐	22	Medicare Supplement Insurance Experience Exhibit	1	EO	xxx	3/1	NAIC	
☐	23	Risk-Based Capital Report	1	EO	xxx	3/1	NAIC	
☐	24	Schedule SIS	1	N/A	N/A	3/1	NAIC	
☐	25	Supplemental Compensation Exhibit	1	N/A	N/A	3/1	NAIC	
☐	26	Supplemental Health Care Exhibit (Parts 1 and 2)	1	EO	xxx	4/1	NAIC	
☐	27	Supplemental Investment Risk Interrogatories	1	EO	xxx	4/1	NAIC	
		III. ELECTRONIC FILING REQUIREMENTS						
☐	61	Annual Statement Electronic Filing	xxx	EO	xxx	3/1	NAIC	
☐	62	March .PDF Filing	xxx	EO	xxx	3/1	NAIC	
☐	63	Risk-Based Capital Electronic Filing	xxx	EO	N/A	3/1	NAIC	
☐	64	Risk-Based Capital .PDF Filing	xxx	EO	N/A	3/1	NAIC	
☐	65	Supplemental Electronic Filing	xxx	EO	xxx	4/1	NAIC	
☐	66	Supplemental .PDF Filing	xxx	EO	xxx	4/1	NAIC	
☐	67	Quarterly Statement Electronic Filing	xxx	EO	xxx	5/15, 8/15, 11/15	NAIC	
☐	68	Quarterly .PDF Filing	xxx	EO	xxx	5/15, 8/15, 11/15	NAIC	
☐	69	June .PDF Filing	xxx	EO	xxx	6/1	NAIC	
		IV. AUDIT/INTERNAL CONTROL RELATED REPORTS						
☐	81	Accountants Letter of Qualifications	1	EO	N/A	6/1	Company	
☐	82	Audited Financial Reports	1	EO	xxx	6/1	Company	
☐	83	Audited Financial Reports Exemption Affidavit	1	N/A	N/A		Company	
☐	84	Communication of Internal Control Related Matters Noted in Audit	1	EO	N/A	8/1	Company	
☐	85	Independent CPA (change)	1	N/A	N/A		Company	
☐	86	Management's Report of Internal Control Over Financial Reporting	1	N/A	N/A	8/1	Company	
☐	87	Notification of Adverse Financial Condition	1	N/A	N/A		Company	
☐	88	Relief from the five-year rotation requirement for lead audit partner	1	EO	xxx	3/1	Company	
☐	89	Relief from the one-year cooling off period for independent CPA	1	EO	xxx	3/1	Company	
☐	90	Relief from the Requirements for Audit Committees	1	EO	xxx	3/1	Company	
☐	91	Request for Exemption to File Management's Report of Internal Control Over Financial Reporting	1	N/A	N/A		Company	
		V. STATE REQUIRED FILINGS						
☐	101	Certificate of Compliance	0	0	1	3/1	Domicile	
☐	102	Certificate of Deposit	0	0	1	3/1	Domicile	
☐	103	Corporate Governance Annual Disclosure*** **(Not applicable to HSC/HMOs)**	0	0	0	6/1	Company	
☐	104	Certificate of Valuation	0	0	0	If requested only	Domicile	
☐	105	Complaint System Summary (HMOs only)	1	0	0	3/1	Company	
☐	106	Annual Statement Montana State Page	1	0	1	3/1	Company	
☐	107	Filings Checklist Page 1 (with Column 1 completed)	1	0	1	3/1	State	
☐	108	Genetics Program Charge Form	1	0	1	3/1	State	
☐	109	Form B-Holding Company Registration Statement	1	0	0	4/30	State	
☐	110	Form F-Enterprise Risk Report ***	1	0	0	4/30	State	
☐	111	ORSA ****	1	0	0	4/30	Company	
☐	112	Montana Premium Tax Report and Remittance	1	0	1	3/1	State	
☐	113	State Filing Fees	1	0	1	3/1	State	
☐	114	Quarterly Premium Tax Payments	1	0	1	4/15, 6/15, 9/15, 12/15	State	
☐	115	Quarterly Provider List Updates (HMOs only)	1	0	0	3/1, 5/15, 8/15, 11/15	Company	
☐	116	Report of Insured Montana Residents	1	0	1	3/1	State	

***If XXX appears in this column, this state does not require this filing, if hard copy is filed with the state of domicile and if the data is filed electronically with the NAIC. If N/A appears in this column, the filing is required with the domiciliary state. EO (electronic only filing).**

****If Form Source is NAIC, the form should be obtained from the appropriate vendor.**

*****For those states that have adopted the NAIC Corporate Governance Annual Disclosure Model Act, an annual disclosure is required of all insurers or insurance groups by June 1. The Corporate Governance Annual Disclosure is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL:** http://www.naic.org/public_lead_state_report.htm.

******For those states that have adopted the NAIC updated Holding Company Model Act, a Form F filing is required annually by holding company groups. Consistent with the Form B filing requirements, the Form F is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state. For more information on lead states, see the following NAIC URL:** http://www.naic.org/public_lead_state_report.htm

*******For those states that have adopted the NAIC Risk Management and Own Risk and Solvency Assessment Model Act, a summary report is required annually by insurers and insurance groups above a specified premium threshold. The ORSA Summary Report is a state filing only and should not be submitted by the company to the NAIC. Note however that this filing is intended to be submitted to the lead state if filed at the insurance group level. For more information on lead states, see the following NAIC URL:** http://www.naic.org/public_lead_state_report.htm

	NOTES AND INSTRUCTIONS (A-K APPLY TO ALL FILINGS)
A	**Required Filings Contact Person**: Montana Commissioner of Securities and Insurance, Examinations Bureau: 406-444-2040 or Fax 406-444-3497 E-mail Address: CSIExams@mt.gov
B	**Mailing Address**: Montana Commissioner of Securities and Insurance Examinations Bureau 840 Helena Avenue Helena, MT 59601
C	**Mailing Address for Filing Fees**: **Domestic & Foreign HSC/HMOs** - The mailing address is same as B. **DOMESTIC Health Service Corporations (HSC) and Health Maintenance Organizations (HMO)**: The certificate of authority is continuous in nature subject to renewal with payment of $300 renewal fee. The annual statement filing fee is $25. Both fees are due March 1. **Please use the HSC/MHO Renewal** included in this filing packet to pay these fees and any applicable Health Service Corporation Fees **SEE NOTE "CC"**. **FOREIGN Health Service Corporations (HSC) and Health Maintenance Organizations (HMO)**: The certificate of authority is continuous in nature subject to renewal with payment of $300 renewal fee (or Retaliatory Fee if applicable). Fee is due March 1. **Please use the HSC/MHO Renewal** included in this filing packet to pay this fee any applicable Health Service Corporation Fees **SEE NOTE "CC"**. Applicable State Forms are required for Disability Authority reporting. Please contact Michelle Scaccia with questions.
D	**Mailing Address for Premium Tax Payments**: **HSCs and HMOs:** No premium tax applicable.
E	**Delivery Instructions**: Make checks payable to "Commissioner of Insurance, State of Montana." **HSC and HMOs:** All filings must be postmarked no later than the indicated due date. If due date falls on weekend or holiday, deadline extends to next business day.
F	**Late Filings**: **HSC and HMOs:** The commissioner may suspend or revoke a license or impose a fine if filings are not made in time provided [Sections 33-30-107(4) and 33-31-211(2), MCA].
G	**Original Signatures**: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Foreign insurers may use facsimile signatures or reproductions of original signatures on Signed Jurat page.
H	**Signature/Notarization/Certification:** The annual statement must be verified by the oath of the insurer's president or vice-president and secretary or, if a reciprocal insurer, by the oath of the attorney-in-fact or its like officers if a corporation.
I	**Amended Filings**: See NAIC Annual Statement Instructions for guidance on amended filings.
J	**Exceptions from normal filings**: Companies must submit a written request for an exemption or extension to the Department of Insurance. Foreign companies must include a copy of any exemption or extension received by its state of domicile to receive such from Montana.
K	**Bar Codes (State or NAIC)**: Montana is not currently using Bar Codes.
L	**Signed Jurat**: Domestic insurers must submit an annual statement with original signatures on the Jurat page. Montana waives foreign insurers from filing printed annual statements and NAIC supplements if filed with the state of domicile and the NAIC, and if filed electronically with the NAIC.
M	**NONE Filings**: See NAIC Annual Statement Instructions. Exceptions are noted in the instructions.
N	**Filings new, discontinued or modified materially since last year**: None of the filings have been discontinued since last year.
O	**Annual Statement Filing:** **DOMESTIC HMOs Operating as a Plan of a Health Service Corporation:** HMOs operating as a plan of a HSC are required to file the following sections from the annual statement on the standard NAIC blank for Health Companies: Cover Jurat Statement of Revenue and Expenses Cash Flow Analysis of Operations by Lines of Business Underwriting & Investment Exhibit, Part 1, Part 2, Part 2A, Part 2B, Part 2C, Sections A, B & C, and Part 3 Exhibit 4 – Claims Unpaid and Incentive Pool, Withhold and Bonus (Reported and Unreported) Exhibit 7 – Part 1, Summary of Transactions with Providers Exhibit 7 – Part 2, Summary of Transactions with Intermediaries General Interrogatories Five-Year Historical Data Exhibit of Premiums, Enrollment and Utilization

P	**Quarterly Financial Statement Filing**: **DOMESTIC HMO's Operating as a Plan of a Health Service Corporation:** HMOs operating as a plan of a HSC are required to file on the dates noted above the following sections from the quarterly statement on the NAIC blank for Health Companies: Cover Jurat Statement of Revenue and Expenses Cash Flow Exhibit of Premiums, Enrollment and Utilization Claims Unpaid and Incentive Pool, Withhold and Bonus (Reported and Unreported) Underwriting and Investment Exhibit – Analysis of Claims Unpaid – Prior Year – Net of Reinsurance
Q	**Certificate of Compliance**: Each foreign insurer shall file a Certificate of Compliance issued by the public official having supervision of insurance in the insurer's state of domicile. It shall certify that the company is duly organized and authorized to transact insurance therein and the kinds of insurance it is authorized to transact. Due March 1.
R	**Certificate of Deposit**: Each foreign insurer shall file a Certificate of Deposit issued by the official having supervision of insurance in the insurer's state of domicile. It shall certify the amount and the composition of the deposit maintained by the insurer in another state for the protection of all policyholders, along with a detailed description, including CUSIP# (if available), par value, and/or amortized value and/or market value for each security listed based on the information maintained by insurer's state of domicile. Due March 1.
S	**Certificate of Valuation**: T**his state does not require this filing, if hard copy is filed with the state of domicile and if the report can be provided should our agency request a report.**
T	**Complaint System Summary**: **DOMESTIC HMOs only:** Section 33-31-303(1)(e), MCA, states HMOs must annually file a complaint system summary based on the requirements in 33-31-303(1)(d), MCA. There is no particular reporting form provided by this Department, therefore, the HMO may report this information in any format desired, as long as all statutory requirements are included. Due March 1.
U	**Genetics Program Charge Form** Pursuant to Section 33-2-712 MCA, an insurer is required to pay a fee of $1.00 to the Commissioner of Insurance per Montana resident insured under any individual or group disability or health insurance policy on February 1 of each year. Payments for Genetics Program Charges should be made by attaching a **SEPARATE CHECK FOR THE AMOUNT DUE.** A Genetics Program Charge Form is required if your company is licensed to transact Disability (Health) insurance in Montana. Due March 1. **NO FILING REQUIRED IF NO DATA TO REPORT**
V	**Insurance Department Financial Examination Report**: **This state does not require this filing, if hard copy is filed with the state of domicile and if the report is filed electronically with the NAIC.**
W	**Quarterly Premium Tax Forms and Instructions** **HSCs and HMOs:** No quarterly premium tax applicable.
X	**Quarterly Provider List Updates**: **DOMESTIC AND FOREIGN HMOs only:** HMOs are required to submit quarterly updates to the provider list so that the department is aware of any new or terminated providers. The provider list and quarterly update may be submitted in any logical format desired.
Y	**Report of Insured Montana Residents:** This report is required if your company is licensed to transact Disability (Health) insurance in Montana and may be submitted as part of the OPTINS filing. Due March 1. **NO FILING REQUIRED IF NO DATA TO REPORT**
Z	**Audited Financial Statements**: **FOREIGN INSURERS ONLY** – Please refrain from submitting the Audited Financial Statements to this office until further notice.
AA	**Statement of Actuarial Opinion**: Domestic insurers are required to submit the actuarial opinion, including a copy of the actuarial report supporting the actuarial opinion together with related actuarial work papers. Due March 1.
BB	**Health Service Corporation (HSC) Fee:** Mont. Code Ann. §33-2-714: "An authorized health service corporation as defined in 33-30-101 shall file with the commissioner, on or before March 1 of each year, a report in a format prescribed by the commissioner showing the total direct premium income during the preceding calendar year from all sources after deducting from the income applicable cancellations, returned premiums, or the amount of reduction in or refund of premiums. At the time the report is filed, and subject to 33-2-709, the health service corporation shall pay a fee to the commissioner on net premium income computed at the rate of 1%." **DOMESTIC Health Service Corporations (HSC):** Health Service Corporation Fees (HSC Fees) are due March 1. **Please use the HSC/MHO Renewal** included in this filing packet to pay these fees and any applicable filing fees **SEE NOTE "C"**. **FOREIGN Health Service Corporations (HSC)**: HSC Fees are due March 1. **Please use the HSC/MHO Renewal** included in this filing packet to pay this fee any applicable filing fees **SEE NOTE "C"**.

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Please Note: **This state's instructions for companies to file with the NAIC are included in this Checklist. The NAIC will not be sending their own checklist this year.**

Electronic Filing is intended to be filing(s) submitted to the NAIC via the NAIC Internet Filing Site which eliminates the need for a company to submit diskettes or CD-ROM to the NAIC. Companies are not required to file hard copy filings with the NAIC.

Column (1) Checklist
Companies may use the checklist to submit to a state, if the state requests it. Companies should copy the checklist and place an "x" in this column when submitting information to the state.

Column (2) Line #
Line # refers to a standard filing number used for easy reference. This line number may change from year to year.

Column (3) Required Filings
Name of item or form to be filed.

The ***Annual Statement Electronic Filing*** includes the annual statement data and all supplements due March 1, per the *Annual Statement Instructions.* This includes all detail investment schedules and other supplements for which the *Annual Statement Instructions* exempt printed detail.

The ***March.PDF Filing*** is the .pdf file for annual statement data, detail for investment schedules and supplements due March 1.

The ***Risk-Based Capital Electronic Filing*** includes all risk-based capital data.

The ***Risk-Based Capital.PDF Filing*** is the .pdf file for risk-based capital data.

The ***Supplemental Electronic Filing*** includes all supplements due April 1, per the *Annual Statement Instructions.*

The ***Supplemental.PDF Filing*** is the .pdf file for all supplemental schedules and exhibits due April 1.

The ***Quarterly Electronic Filing*** includes the complete quarterly filing and the PDF files for all quarterly data.

The ***Quarterly.PDF Filing*** is the .pdf file for quarterly statement data.

The ***June.PDF Filing*** is the .pdf file for the Audited Financial Statements and Accountants Letter of Qualifications.

Column (4) Number of Copies
Indicates the number of copies that each foreign or domestic company is required to file for each type of form. The Blanks (EX) Task Force modified the 1999 *Annual Statement Instructions* to waive paper filings of certain NAIC supplements and certain investment schedule detail, if such investment schedule data is available to the states via the NAIC database. The checklists reflect this action taken by the Blanks (EX) Task Force. XXX appears in the "Number of Copies" "Foreign" column for the appropriate schedules and exhibits. **Some states have chosen to waive printed quarterly and annual statements from their foreign insurers and have chosen to rely upon the NAIC database for these filings. This waiver could include supplemental annual statement filings. The XXX in this column might signify that the state has waived the paper filing of the annual statement and all supplements.**

Column (5) Due Date
Indicates the date on which the company must file the form.

Column (6) Form Source
This column contains one of three words: "NAIC," "State," or "Company," If this column contains "NAIC," the company must obtain the forms from the appropriate vendor. If this column contains "State," the state will provide the forms with the filing instructions (generally, on the state web site). If this column contains "Company," the company, or its representative (e.g., its CPA firm), is expected to provide the form based upon the appropriate state instructions or the NAIC *Annual Statement Instructions*.

Column (7) Applicable Notes
This column contains references to the Notes to the Instructions that apply to each item listed on the checklist. The company should carefully read these notes before submitting a filing.

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE 840 HELENA AVENUE HELENA, MONTANA 59601 (406) 444-2040	**HSC/HMO Annual Renewal** **Filing Made During the Year 2025** **Mont. Code Ann.** **§ 33-30-204 and § 33-31-212**

Name of Company _____ NAIC Number _____

Mailing Address - Street or PO Box No. _____

City, State, Zip _____

Printed Name and Title of Person Completing Form _____ Direct Telephone Number _____

Health Service Corporation (HSC) Fee - Mont. Code Ann. §33-2-714: "An authorized health service corporation as defined in 33-30-101 shall file with the commissioner, on or before March 1 of each year, a report in a format prescribed by the commissioner showing the total direct premium income during the preceding calendar year from all sources after deducting from the income applicable cancellations, returned premiums, or the amount of reduction in or refund of premiums. At the time the report is filed, and subject to 33-2-709, the health service corporation shall pay a fee to the commissioner on net premium income computed at the rate of 1%."

1. 2024 Direct Premium Income* $_____
2. Additional Deductions** (explanation required)
   a. Cancellations _____
   b. Returned premium _____
   c. Amount of reduction or refund of premium _____
3. Net Premium Income (Line 1 – Lines 2a, 2b and 2c) $_____
4. **HSC Fee** (Line 3 x $0.01) **(not applicable to HMOs)** **$_____**
5. **HSC/HMO COA Continuation Fee $300.00** **$ 300.00**
6. **HSC/HMO Annual Statement filing fee $25.00** **$ 25.00**
7. **Retaliatory Amount (if applicable)** **$_____**
8. **Total Remittance** **$_____**

Please make your check payable to: Commissioner of Insurance, State of Montana.
Please remit your check and this form to the address above.

*If Direct Premium Income reported on Line 1, above, does not match Column 1, Line 12 of the Montana State Page (page 30) of the 2024 Annual Financial Statement filed with this Office, please include a written explanation with the form when submitted.
**Direct premium Income on line 1 should already be net of all deductions. If additional deductions are taken, please include a written explanation with the form when submitted.

The above statement is a true and correct report of premiums collected and of authorized deductions pertaining to business transacted in Montana in the past calendar year and are in accordance with the requirements of the applicable statutes.

Title of Officer	Name of Officer
Date	Signature of Officer

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

GENETICS PROGRAM CHARGE

Mont. Code Ann. § 33-2-712

Name of Company _____ NAIC Number _____

Mailing Address - Street or PO Box No. _____

City, State, Zip _____

Printed Name and Title of Person Completing Form _____ Telephone Number _____

To be charged upon every HEALTH OR DISABILITY INSURER, HEALTH SERVICE CORPORATION and the MONTANA STATE GROUP HEALTH SELF-INSURANCE PLAN an annual fee of **$1.00** for each Montana resident insured under any **individual or group disability or health insurance policy** which includes dental, vision, long-term care and Medicare supplemental insurance, in effect as of February 1 of each year for the purpose of funding the Genetics Program. **FORM DUE MARCH 1**

Disability insurance (Section 33-1-207, MCA), including credit disability insurance, is insurance of human beings against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or against disablement or medical expense or indemnity resulting from sickness.

Please provide explanation if fee (or any portion of fee) is not applicable: _____

_____

Number of Montana residents insured under any individual or group health or disability insurance policy in effect as of February 1, 2025 . . . . . _____

Genetics Charge $1.00 . . . . . **X 1.00**

Total Due . . . . . _____

Please make your check payable to: Commissioner of Insurance, State of Montana.

The above statement is a true and correct report of business transacted in Montana and has been prepared in accordance with the requirements of the applicable statutes.

(Title of Officer) _____ (Name of Officer)

(Date) _____ (Signature)

MONTANA COMMISSIONER OF SECURITIES AND INSURANCE
840 HELENA AVENUE
HELENA, MONTANA 59601
(406) 444-2040

Report of Insured Montana Residents

under health or disability insurance policies
(report due March 1)

Mont. Code Ann. § 33-2-704

NO FILING REQUIRED IF NO DATA TO REPORT

(Name of Company) (N.A.I.C. #)

(Mailing Address - Street or P.O. Box) (City-State-ZIP)

Section 33-2-704, MCA, requires each insurer providing health or disability insurance to report the number of Montana residents insured under any policy of individual or group health or disability insurance. If your company provides excess of loss or stop loss health or disability insurance, you must also include in your count of covered individuals all Montana residents whose coverage is reinsured in whole or in part by your company. For the purposes of this report, February 1, 2025 should be used as the date for determining the number of Montana residents insured.

An excess of loss or stop loss health or disability insurer may exclude from its count of insured individuals those who have been counted by a primary health or disability insurer or a primary reinsurer. However, the insurer should include in its count the number of individuals it covers under an excess of loss or stop loss health or disability policy for which the individuals have not been counted by a primary insurer. For example, the insurer should include all individuals in its count if excess of loss or stop loss health or disability insurance policies are issued to self-insured employers or plans, multiple employer welfare arrangements, or any other health insurance situations in which first dollar coverage is not provided by a primary insurer.

IMPORTANT!: If the number of Montana residents insured by health or disability insurance is not known, provide an estimate as directed on the reverse side of this form.

1. Number of Montana residents insured under any individual or group health or disability insurance policy, including excess of loss or stop loss insurance policies covering health or disability insurance in effect as of February 1, 2025 _____

2. The number of insured lives reported on line 1 above is based on (check one of the following boxes):

   (a) An actual count of lives insured . . . . . [ ] (actual)

   (b) An estimated count of lives insured, pursuant to the directions on the reverse side of this form . . . . . [ ] (estimate)

The foregoing is a full, true and correct statement according to the best of my knowledge, information, and belief.

(Name and title of person preparing report) (Telephone Number) (Email address)

INSTRUCTIONS FOR ESTIMATING THE COUNT OF INSURED LIVES

The following are guidelines for estimating the number of insured lives in Montana covered by disability insurance (as defined in 33-1-207, MCA) by your company.

For indemnity and HMO disability insurance plans, estimate this number of insured lives by following these steps. A demonstration of the calculation shown in steps 5 and 6 below, shown separately for each disability insurance policy form with premium volume in Montana, must accompany this estimate.

1. Determine the total disability insurance premium on policies in force during the year, separately for each policy form.

2. For each policy form, determine the "average plan" sold under that form. Plans may be differentiated by deductible/coinsurance level or by other features unique to specific plans. The "average plan" is the plan which most nearly represents the total plans sold under that policy form. This could be the plan with the highest premium volume, a plan between (in value) two or more plans with significant premium volumes, or a plan selected by some other indication that it fairly represents an average of the plans sold.

3. Determine the gross premium for each average plan for each of the following family categories: (a) a single insured individual; (b) an insured individual and spouse; (c) an insured family (that is, an insured individual, the spouse and the children); and (d) an insured individual and the children. Each gross premium should be based on policyholder characteristics which affect the rates (such as age, geographic area, occupation, etc.) that fairly represent an average for the blocks of business covered by the policy. This yields the average gross premium for each family category for each average plan under each policy form and is represented by "Average Gross Premium$_y$" in the formula in step 5 below, where "y" refers to one of the four family categories described above.

4. Determine the average distribution of the four family categories above. That is, determine what percent of policies are sold to single individuals, what percent are sold to individual and spouse combinations, and so on. This distribution could change from policy to policy. Each percentage is represented by "Percent$_y$" in the formula in step 5 below.

5. Calculate the policy form's average premium per insured using the formula:

$$\frac{\Sigma_{\text{all y}}\ \text{Average Gross Premium}_y \times \text{Percent}_y}{\Sigma_{\text{all y}}\ \text{Average Number of Insureds}_y \times \text{Percent}_y} = \text{Average Premium per Insured}$$

   The "Average Number of Insureds$_y$" for each family category is as follows: 1 for a single insured individual, 2 for an insured individual and spouse, 4 for an insured family and 3 for an insured individual with children.

6. Calculate the total number of insureds for the policy form as follows:

$$\frac{\text{Total In Force Premium}}{\text{Average Premium per Insured}} = \text{Total Number of Insureds}$$

7. The final step is to add all the estimates of number of insureds under each disability insurance policy form to arrive at a single estimate.

Stop loss and excess of loss insurers must contact each entity insured by these coverages to obtain the number of insureds, including dependents, covered under the contract, and add these counts. The insurer must demonstrate the method of determining the total number by submitting the name of each entity covered under the contract and the total number of insureds covered under each. If this number includes insureds which were counted by a primary insurer, submit the number of lives which were already counted, then subtract that number from the total number to get the number of lives not already counted. Be sure to submit all three numbers.