State of Kansas
Department of Insurance

Annual Report

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Company Name: _____

DBA NAME: _____

License #: _____ FEIN: _____ _

Business Address:

_____

Mailing Address:

Business Phone: _____ Business E-mail:_____

Business Website: _____

Contact Person: _____ Title: _____

Contact Phone: _____ Contact E-mail: _____

Submission:

e-mail: Jordan.Devlin@ks.gov
Subject: [year] Annual Report – [company name]

Mail: Kansas Insurance Department
Health & Life Division
Attn: Jordan Devlin
1300 SW Arrowhead Road
Topeka, KS 66604

Background Information

Please read and answer the following questions:

YES NO

1. Has there been any administrative action taken against the administrator in another jurisdiction or by another governmental agency within the last year?

   If you answer yes, please provide the following:
   a. a copy of the order,
   b. consent order, and
   c. other relevant legal documents.

2. Has any owner, partner, officer or director been involved in an administrative proceeding regarding any professional or occupational license within the last year?

   If you answer yes, please provide the following:
   a. a written statement identifying the type of license and explaining the circumstances of each incident,
   b. a copy of the Notice of Hearing or other document that states the charges and allegations, and
   c. a copy of the official document which demonstrates the resolution of the charges or any final judgment.

3. Has there been a change of officers within the last year?

   If you answer yes, please provide the following:
   a. a list of the new officers and their position.

4. Does the administrator administer, or will be administering, self-funded health plans subject to regulation under chapter 40, Kansas Statutes Annotated?

List of Insurer and Self-Funded Plans

On a separate attachment, please include the following information:

List of insurer and self-funded plans the administrator had agreements with during the preceding fiscal year.

Include:

Insurance Company Name
NAIC#
Address
City, State, Zip Code
Contact Telephone Number
Number of Kansas residents covered by plan

Employer and Trust Name
Address
City, State, Zip Code
Contact Telephone Number
Number of Kansas residents covered by plan

In addition, please provide the following information:

Is your stop-loss carrier admitted to do business in Kansas?

Please provide the name of the stop-loss carrier(s) utilized.

Officers Verification

The report must be verified by at least two (2) officers of the administrator

Annual Report for the fiscal year ending: _____

The officers of this reporting entity being duly sworn, each depose and say that they are the described officers of said reporting entity, and that on the reporting period stated above, all of the herein described assets were the absolute property of the said reporting entity, free and clear from any liens or claims thereon, except as herein stated, and that this statement is in full and true answered of all the assets and liabilities of the condition and affairs of the said reporting entity as of the reporting period stated above and of its income and deductions therefrom for the period ended and have been completed in accordance with the Generally Accepted Accounting Principles according to the best of their information, knowledge and belief, respectively.

The undersigned owner, partner, officer or director of the applicant hereby certifies, under penalty of perjury, that all of the information submitted in this reporting and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the applicant to civil or criminal penalties as determined by a court of law.

_____	_____
Signature	Date
_____	_____
Printed Name	Title
_____	_____
Signature	Date
_____	_____
Printed Name	Title