

**Report of Multiple Medicare Supplement Coverage in Force for Michigan Residents**

**SUBMISSION REQUIRED BY:**  
**Insurers, HMOs and Health Care Corporations providing medicare supplemental coverage in Michigan.**

**Due on or before March 1 each year**

Name and address of Company	N.A.I.C. Group code	N.A.I.C. Company code
	Name and phone number of person to contact with questions regarding this report:	

**Instructions:** Identify each Michigan resident for which the company has more than 1 medicare supplemental coverage plan in force. Give contract, policy or certificate number of each coverage plan in force, for each individual. Show date of issue of each coverage plan. If necessary, attach additional sheets, or a printout of the information in the same format as this form. If additional pages are attached, include company name, NAIC company code and contact person with phone number on each page.

Covered Individual's Name or Identification	Policy, Certificate and Contract Numbers		Date of Issue
	Individual Plan Number	Group Plan and Member Number	

**Certification:** I certify that I have examined this report and any attachments submitted with it, and it is complete and correct.

Authorized signer	Date signed	Authorized signer's name and title (typed or printed)
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**Due on or before March 1, each year**  
**Please DO NOT return this report with company's Annual Statement filing**

**Return completed report directly to:**  
**Office of Financial and Insurance Services**  
**Securities and Insurance Offerings Division**  
**PO Box 30220**  
**Lansing MI 48909-7720**

Michigan Public Act 170 of 1990, Sec. 2272c and Act 89 of the HMO Act of 1990, Sec. 21054k require insurers and health maintenance organizations to report to the Commissioner, information about every individual resident of this state for which the insurer has in force more than 1 medicare supplemental insurance policy, certificate or contract.