

Michigan Health Insurance Enrollment, Premiums & Losses

Name of Company

NAIC Number

Submission Required By:  
 All Property & Casualty Insurers  
 All Life & Health Insurers  
 All Health Maintenance Organizations  
 All HMDI, All AFDS  
 All Fraternal Benefit Societies

2008

DUE

3/1/09

Bar Code Required - Place Bar Code Here

Read instructions before completing form

This table continues on page 2

		Policies in Force	Member Months	Number of Lives	Direct Premiums Written	Direct Losses Paid
<b>Individual Business</b>	1 Major Medical-PPA					
	2 Major Medical-no PPA					
	3 Disability Income					
	4 Medicare Supplement					
	5 Medicare Advantage					
	6 Medicare Part D					
	7 High Deductible w/HSA					
	8 Short term or 1-time limited duration					
	9 MIChild					
	10 Long Term Care					
	11 Dental					
	12 Vision					
	13 Prescription Drug					
	14 Other: Identify					
	15 Total Individual					
<b>Group Business</b>	16 Small Employer Major Medical (<51)-PPA panel					
	17 Small Employer Major Medical (<51)-no PPA panel					
	18 Large Employer Major Medical (>50)-PPA panel					
	19 Large Employer Major Medical (>50)-no PPA panel					
	20 Union/Taft Hartley Plan Major Medical					
	21 Association Major Medical Medical					
	22 Student Medical: Identify					
	23 Disability Income					
	24 Medicare Supplement					
	25 Medicare Advantage					
	26 Medicare Part D					
	27 High Deductible w/HSA					
	28 StopLoss/Excess Loss					
	29 Short term or 1-time limited duration					
	30 MIChild					
	31 Long Term Care					
	32 Dental					
	33 Vision					
	34 Prescription Drug					
	35 Medicaid					
	36 Other -Identify					

Continued from page 1

	Policies in Force	Member Months	Number of Lives	Direct Premiums Written	Direct Losses Paid
37 Total Group					
38 Grand Total (tie to state page)					

**Instructions for completing form FIS 0322**

All insurers with accident and health authority, disability income authority (including life, and casualty insurers), all nonprofit health care corporations, all nonprofit dental care corporations, all health maintenance organizations, and all alternative financing and delivery systems are required to submit an accurate and complete form FIS 0322. Industry analysts, policy makers and researchers use these data to understand more about Michigan's health insurance market. You must submit a form by the due date, even if your company has had no activity during the year.

The grand totals on this form must equal amounts reported as Michigan business on your annual statement, as shown below:

- Property & Casualty Statement**-Grand Totals to equal sum of lines 13 through 15.8 on page 19
- Life & Accident & Health Statement**-Grand Totals to equal line 26 on page 24
- Fraternal Statement**-Grand Totals to equal line 26 on page 23
- Health Statement**-Grand Totals to equal totals on the Exhibit of Premiums Enrollment and Utilization and totals on the Underwriting and Investment Exhibit, Part 1.

Complete all columns for each line where business is reported.

Enter all monetary amounts in whole dollars.

**Column Instructions:**

Column 1-Report the number of policies and group agreements in force as of December 31 of the reporting year. This is the number of individual policies or group policies in force that cover any Michigan citizens, not the number of lives covered under those policies.

Column 2-A member month is coverage for one month for one covered person. It is a measure of

exposure. Member months includes dependents as well as a named insureds or subscribers.

Column 3-Total number of Michigan lives as of December 31 of the reporting year. This number is the total of the policyholders/subscribers plus all covered dependents, including spouses.

Column 4-Direct Premium Written. This amount should include premiums for the full policy term arising from policies written during the year.

Column 5-Direct losses paid include all claims on direct business paid during the year.

**Line Instructions:**

Lines 1 through 7-Major Medical includes major medical, comprehensive medical and other hospital-surgical-medical benefit plans designed to be the insured's primary healthcare coverage. The term does not include short-term or 1-time limited duration coverage, accident-only, specified disease, individual hospital indemnity, credit, dental-only, visual only, prescription drug only, Medicare supplement, Medicare + Choice, long-term care, disability income insurance, MICHild, coverage issued as a supplement to liability insurance, workers compensation or similar insurance, or automobile medical-payment insurance.

Lines 8 and 29-A short term or 1-time limited duration policy is an individual health policy or certificate that does not cover pre-existing conditions and is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy. It must be nonrenewable, except that the health insurer may provide coverage for 1 or more subsequent 185 day or less periods, if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of

the policy. It must be available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the health insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement. Short term individual policies should be reported in the individual section. Short term individual certificates under a group contract issued to a trust should be reported in the group section.

Line 28-Stop Loss/Excess Loss is primary insurance coverage that reimburses an employer or other sponsor of a self-funded health benefit plan for claims beyond a specified specific and/or aggregate attachment point. It does not include a minimum premium plan, which should be reported as employer, union, or association major medical business, as applicable.

Lines 10 and 31-Long term care. Report qualified and non-qualified.

Lines 1, 2, 16-19-PPA means Prudent Purchase Agreement, i.e. a policy that requires or encourages the use of a particular panel of providers for benefits under a policy or contract.

Lines 4 and 24-Medicare Supplement is defined in the NAIC annual statement instructions.

Line 7 and 27-High Deductible with HSA means a high deductible medical insurance policy designed to attach after a high deductible funded by a Health Savings Account.

Line 21-For association business, the number of groups means the number of associations, not the number of groups within the association. The total number of lives includes all the member or employees of all the groups that make up every association covered.

Line 9 and 30-MICHild means policies issued through the MICHild program, administered by the Michigan Department of Community Health.

Address questions regarding this form to: <b>Office of Financial &amp; Insurance Regulation</b> Policy Division Toll free: (877) 999-6442 or Lansing area: (517) 373-1866	Return completed form with your Michigan Annual Statement filing or send to this address before the due date: <b>OFIR - Policy Division</b> PO Box 30220 Lansing MI 48909-7720
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**CERTIFICATION** I certify that I am an officer of the company named in this report and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature of Company Officer	Date signed
Company Officer's name and title typed or printed	Person and phone no. to contact regarding this report:

PA 218 of 1956 as amended requires filing by all insurers, HMOs and AFDS. Failure to file properly could result in a compliance action against the company.



**Michigan Department of Labor & Economic Growth**

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