

## State of Arizona Advertising Transmittal and Certification Form

NAIC # \_\_\_\_\_  
 Company Name \_\_\_\_\_  
 Company Address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

For Department of Insurance Use Only

Date Received \_\_\_\_\_  
 Analyst \_\_\_\_\_  
 Filed: Date \_\_\_\_\_ Initials \_\_\_\_\_

Type of Entity:           Insurance Company  
                               Health Care Services Organization  
                               Hospital, Medical, Dental, Optometric Service Corporation  
                               Prepaid Dental Plan

Contact Person\* \_\_\_\_\_ Title \_\_\_\_\_  
 Telephone Number \_\_\_\_\_ FAX Number \_\_\_\_\_

**Type of Advertising Material Being Filed:**

Radio Commercial	Television Commercial	Brochure
Billboard	Magazine	Newspaper
Internet Web Site	Mailer	Response Card
Other _____ (Describe)		

**Planned Use:**

Date advertising form(s) will first be used \_\_\_\_\_  
 Markets advertising form(s) will be used in \_\_\_\_\_  
 Number of times advertising form(s) will be shown or printed \_\_\_\_\_

**Product(s) Being Advertised:**

Cancer/Specified Disease	Major Medical	Vision Care
Dental	Medicare Risk	Prepaid Dental
Hospital Surgical	Medicare Select	HCSO
Hospital Indemnity	Medicare Supplement	Other _____ (Describe)
LTC/Home Healthcare		

<u>Form Number</u>	<u>Form Name</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Note: Additional forms should be listed on a separate sheet and attached to this Transmittal Form.

**Company Officer Certification**

I have reviewed or supervised the review of the above forms. To the best of my knowledge and belief they are in conformance with applicable provisions of Title 20 of the Arizona Revised Statutes; Title 20, Chapter 6 of the Arizona Administrative Code, and applicable orders by the Director of Insurance. I also acknowledge responsibility for the validity, accuracy and completeness of transmittal and enclosures in this filing.

\_\_\_\_\_  
 Signature of Company Officer/Health Plan Corporate Officer

\_\_\_\_\_  
 Typed Name and Title

\_\_\_\_\_  
 Date

\*Person you have designated to receive any 5-day notice.