State of Arizona Health Care Services Organization/Hospital, Medical, Dental, Optometric Service Corporation/Prepaid Dental Plan Transmittal and Certification Form

NAIC# _____

Company Name _____

Company Address _____

_____

_____

Contact Person _____

Telephone Number _____

This Filing is: ☐ Individual ☐ Group
And Is: ☐ New ☐ Resubmission

(Note: Resubmissions must include copy of original disapproval letter.)

For Department of Insurance Use Only

Date received_____ Analyst_____

	Date	Initials
☐ Approved	_____	_____
☐ Filed _____	_____	_____
☐ Disapproved	_____	_____
☐ Withdrawn	_____	_____
☐ Acknowledge Receipt	_____	_____
☐ Other_____	_____	_____

☐ Exempt ☐ With ARS ☐ No

List all forms included in this filing.

Form Number	Name	Replaces
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If additional space is required, please attach a separate sheet.

Type Of Filing (check all that apply):

☐ Contract ☐ Endorsement/Rider/Amendment

☐ Rate ☐ Evidence of Coverage

☐ Medicare+Choice ☐ Medicare Select

☐ Vision Care ☐ Dental

☐ Prepaid Dental ☐ Disclosure Form

☐ Information Packet

☐ Other _____

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