

Office of Commissioner of Insurance  
State of Georgia

Questionnaire for All Health Policy Form Filings.

Responsible Executive Officer or Official Designee Required to Sign and Certify Answers Given

Insurer Name: \_\_\_\_\_ NAIC#: \_\_\_\_\_

Policy Form #: \_\_\_\_\_

Cover Letter Date of Filing: \_\_\_\_\_

Contact: \_\_\_\_\_ Contact Phone: \_\_\_\_\_

GENERAL FORM FILING QUESTIONS

1. Is the filing Group or Individual Health?
2. Does this form replace an existing health insurance policy form for your company? If so, what policy form number does this replace, and when was that form approved?
3. If this is a Policy Form change to an existing, previously approved policy in Georgia, what are the specific changes?
4. If this is a Policy Form change to an existing, previously approved policy in Georgia, why is this change being implemented?
5. Are the benefits in this Policy Form Filing Major Medical or Comprehensive Health coverage in nature?
6. Does the product contain any unique or unusual benefits? If so, what are they?
7. If Group, is the filing intended to be used with Associations as Eligible groups under O.C.G.A. Section 33-30-1(a) or (b)?
8. If this is Association Group health related, have you established any business relationship or agreement with a specific Association that is proposed to be a group health customer for this product?
9. Are new health rates included with this policy form filing?
10. Does this form filing increase benefits or decrease benefits over any previous similar policy forms filings? If so, please explain in detail.
11. Does this policy form filing have managed care provisions? (such as Provider Networks, and/or Utilization Review requirements)

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12. Is this a PPO or an HMO filing?
13. Does the filing include coverage for Prescription Drugs on an inpatient and/or outpatient basis?

#### PRESCRIPTION DRUG FORMULARY QUESTIONS

14. Does the filing make use of a Prescription Drug Formulary? (if your answer is no, you may skip to Question 22.)
15. Describe the administrative arrangement and handling of your Prescription Drug Formulary.
16. Who directs or administers your Prescription Drug Formulary?
17. How do specific legend or generic drugs get on the Formulary?
18. How do drugs move among categories within the Formulary?
19. How frequently have changes in the Formulary content or administration your company uses been made in the past two years?
20. Have you established a procedure to comply with O.C.G.A. Section 33-20A-9(2)? (This Georgia law provision requires an insurer to have a written procedure for formulary drug appeals by a covered enrollee when a formulary equivalent has been ineffective or the formulary drug causes or is reasonably expected to cause adverse or harmful reactions in the patient.)
21. Is your Prescription Drug Formulary alternative procedure clearly disclosed in your policy form materials?

#### CONSUMER IMPACT QUESTIONS:

22. Specifically, how will this change affect policy holders, certificate holders and other consumers?
23. What will policy holders, certificate holders and other consumers expect as a direct result of this change?
24. Does this change affect all policy holders, certificate holders and consumers or only certain ones?

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CONSUMER IMPACT QUESTIONS, (continued)

25. If all above groups (policyholders, certificateholders, etc.) are affected, how will the change be implemented and on what schedule?
26. Will this change mean lower premiums for policy holders, certificate holders and other consumers? If so, when will the saving be passed along to each?
27. Will this change mean savings or increased profitability for the insurer? If so, provide estimates in each category affected.
28. Other than within the wording of the policy or certificate itself, how do you plan to communicate these changes to policy holders, certificate holders and other consumers?
29. What is your communication time line for these changes?

(see next page for Certification and further instructions)

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Instructions: This Questionnaire must be Certified by either a Company Executive Officer or that Executive Officer's Official Designee. If the Executive Officer of the company designates an official Designee on these forms to complete and Certify answers given in this Questionnaire, and/or any future Questionnaires, the Insurer will be held responsible to the same extent as if the Executive Officer gave the Certification directly.

EXECUTIVE OFFICER CERTIFICATION:

Insurer Company Name: \_\_\_\_\_ NAIC #: \_\_\_\_\_

Policy Form Filing Number: \_\_\_\_\_ Cover Letter Date: \_\_\_\_\_

State of \_\_\_\_\_

City of \_\_\_\_\_

I, \_\_\_\_\_  
(Printed Name of Executive Officer [President, CEO, CFO, Treasurer or Corporate Secretary] of Insurer)

do hereby certify that the answers given to the attached Questionnaire are true, correct and complete.

Signed: \_\_\_\_\_  
(Executive Officer Signature)

Title: \_\_\_\_\_

Date: \_\_\_\_\_

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OPTIONAL DESIGNATION of Person or Persons to Certify H-Quest Questionnaires

I, \_\_\_\_\_  
(Printed Name of Executive Officer [President, CEO, CFO, Treasurer or Corporate Secretary] of Insurer)

hereby designate: \_\_\_\_\_  
(Printed Name or Names of Designee or up to 3 Designees of Insurer)

to execute and certify this Questionnaire, and future such Questionnaires on behalf of the Company and agree to furnish a copy of this Designation with future Questionnaires executed on health policy forms by the Company.

Signed: \_\_\_\_\_  
(Executive Officer Signature)

Signed: \_\_\_\_\_  
(Optional Designee Certifier)

Title: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Optional Designee Certifier)

Signed: \_\_\_\_\_  
(Optional Designee Certifier)

Date: \_\_\_\_\_

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DESIGNEE CERTIFICATION:

Insurer Company Name: \_\_\_\_\_ NAIC: \_\_\_\_\_

Policy Form Filing Number: \_\_\_\_\_ Cover Letter Date: \_\_\_\_\_

State of \_\_\_\_\_

City of \_\_\_\_\_

I, \_\_\_\_\_  
(Printed Name of Company Designee Certifier of Insurer)

do hereby certify that the answers given to the attached Questionnaire are true, correct and complete. I am furnishing a copy of my Designation by the Executive Officer, Dated \_\_\_\_\_ as part of this Certification.  
(Date of Optional Designation)

Signed: \_\_\_\_\_  
(Designee Certifier of Insurer)

Title: \_\_\_\_\_

Date: \_\_\_\_\_