[------Attach Check Here------]

MINNESOTA HMO TRANSMITTAL FORM Make checks payable to: Minnesota Department of Health

***DEPARTMENT USE* ONLY**

Accounting: **Record No.** _____

Date **Closed Date** _____

Amt. Rec'd **Analyst** _____ **Status** _____

Suspense Date(s) _____

Company Name:_____Domicile:_____

Date: _____Company NAIC No: _____

IDENTIFY BASE POLICY FORM BEING FILED: _____

LIST FORMS BEING FILED:_____ _____ _____ _____

_____ _____ _____ _____ _____

FILING FOR: *(Check One Only)* _____**Group** _____**Individual**

TYPE OF FILING: (Check One Only)
_____**Forms (2)** (Fee = $125.00)
_____**Rates Only Filing(3)** (Fee = $125 + $30 per product)
_____ **Rates & Forms (5)** (Fee = $250 + $30 per product)

TYPE OF Filing:*(*Check One Only)

HEALTH

___ HMO Small Employer Group (262)
___ HMO Individual (234)
___ HMO Conversion (334)
___ HMO Medicare Supplement (242)
___ HMO Expanded Provider Network (298)

PERSON MAKING THIS FILING: **FOR STATUS REPORTS CALL (651) 282-5605**

NAME_____

TITLE_____

SIGNATURE_____

PHONE NO._____

FAX NO. _____

E-MAIL ADDRESS_____

Edition Date: December 1, 2005

Reset Form