Health Insurance Carrier Survey

Date Completed _____

Insurance Company _____

NAIC# _____

Toll Free Consumer Contact Telephone Number _____

Please check all Line of Authority that your company markets in Delaware.

_____**Group**

_____ Large Employer (50+ Employees) _____Small Employer _____AHP/MEWA Plans

_____ Blanket Insurance _____ Fixed Indemnity Insurance _____ HRA/HSA High Deductible

_____Disability Income Plans _____Short Term Disability _____ Long Term Disability

_____Dental _____Vision _____ Miscellaneous (List plan types below)

_____**Individual**

_____Comprehensive Major Medical _____PPO _____POS _____HMO _____MCO

_____AHP/MEWA Plans _____HRA/HSA High Deductible _____Fixed Indemnity Plans

_____Disability Income Plans _____Short Term Disability _____Long Term Disability

_____Dental _____Vision _____Miscellaneous (List plan types below)

_____**Long Term Care Insurance**

_____Federally Qualified Plans _____Group ____Individual ____LTC Partnership Plans

_____**Medicare Supplement Plans:** Please indicate which plans the company markets.

Comments and Notes:_____

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