



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:
