STATE OF CONNECTICUT

INSURANCE DEPARTMENT

Public Health Fee Assessment Request

For Number of Insured or Enrolled Lives in CT as of May 1st, 2019

Per Conn. Gen. Stat. Sec. 19a-7p

Report Due Date: September 1st, 2019

I.

☐ Domestic Insurer

☐ Health Center

Company Name: _____

Street Address: _____

City, State, Zip: _____

Contact Person: _____

Phone: _____

E-Mail: _____

Note: All letters and email will be sent to this address. Email should be address used for assessment invoices.

Report Number: ***If none, please report as "NONE"*** _____

IV.

The undersigned hereby certifies (a) that he or she duly executed this report on the date shown below on behalf of the company named above as the Reporting Entity; (b) that he or she is an officer or representative of such company and is authorized to make this certification; and (c) that the facts set forth in this Report are true and correct to the best of his/her knowledge, information and belief.

BY _____ _____
(signature) (print date)

_____ _____
(print name) (Title)

Original ink signature not required. Emailed copy is the preferred reporting method.

Electronic Filings:	Electronic filings are **preferred;** sent to cid.phfa@ct.gov
Mailing Address:	Connecticut Insurance Department Attn: Business Office P.O. Box 816 Hartford, CT 06142-0816
Inquiries / Questions?	Please send all inquiries to cid.phfa@ct.gov