**COMPANY SUPERVISION DIVISION**

**2018 Annual Report for a**

**Licensed Health Carrier Doing Business as a**

**Discount Plan(s)**

**For the year ending December 31, 2018**

|  |  |
| --- | --- |
| **Legal Name of Licensed Health Carrier** | **WAOIC No.** |
|  <Enter name here>      |       |

This AnnualReport is to be filed **on or before March 31, 2019** in compliance with RCW 48.155.015(2)(b). Failure to complete this Annual Report as prescribed will subject the health carrier to possible disciplinary action.

1. All pages must be completely filled out.
2. The Annual Report may be filled out using Microsoft WORD.
3. Page 2 of the report must be printed, hand-signed, and notarized.

Electronic signatures are not acceptable.

Per WAC 284-155-030(3):

The Annual Report must be converted to a PDF file format prior to upload.

Upload to our filing portal at:

<https://fortress.wa.gov/oic/onlineservices/Login.aspx?module=FIN>

**See RCW 48.155.110 regarding the $20 annual reporting fee requirement.**

Fee payment: Send your check along with this page (to serve as the backup documentation) to the appropriate address noted below:

**U.S. Mail**: Washington State Office of Insurance Commissioner

Attention: Company Supervision,

P. O. Box 40255,

Olympia, WA 98504-0255

**Hand Delivery**: Washington State Office of Insurance Commissioner

Attention: Company Supervision,

5000 Capitol Boulevard SE,

Tumwater, WA 98501

Do not alter or modify the preprinted language on this form. Please contact Sarah Froyland at (360) 725-7205 or CompanySupervisionFilings@oic.wa.gov if you have any questions regarding this Annual Report.

 ANNUAL REPORT

 For the Year Ended December 31, 2018

OF THE CONDITION AND THE AFFAIRS OF

(Name of Licensed Health Carrier)

 Organized under the Laws of the State of      , made to the

 INSURANCE COMMISSIONER OF THE STATE OF WASHINGTON

 PURSUANT TO THE LAWS THEREOF

Mail Address:

Primary Location of

Books and Records:

Discount Plan Annual Report Contact

Person and Phone Number:

E-Mail Address:

Compliance Officer Responsible for Ensuring Compliance with Chapter

48.155 RCW and Phone Number:

E-Mail Address:

State of

County of

      being duly sworn, says that this annual report is an accurate and true statement of the affairs of said health carrier’s discount plan business.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title:

Subscribed and sworn to before me this

\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2019

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public

My Commission expires \_\_\_\_\_\_\_\_\_\_\_

1. Please provide detail for all Washington discount plan transactions for the year ending December 31, 2018 in the table below:

|  |  |  |
| --- | --- | --- |
|  Entity |  Funds Received | Funds Disbursed |
|
| Aggregate for All WA Members | $       | $       |
| Aggregate for All WA Prospective Members | $       | $       |
| Aggregate for All WA Individual Providers | $       | $       |
| Detail for All WA Provider Networks Identified by Network Name: |
|       | $       | $       |
|       | $       | $       |
|       | $       | $       |
|       | $       | $       |
|       | $       | $       |
|       | $       | $       |
|       | $       | $       |

2.a. Please provide the number of members the discount plan(s) has (have) in Washington as of December 31, 2018:

2.b. Please provide the total number of members the discount plan(s) has (have) as of December 31, 2018:

3.a. If different from the most recent disclosure provided in previous Annual Report, please provide the names and resident addresses of all persons responsible for conduct of the discount plan’s affairs, and whether or not any of these people have or had any contracts or arrangements with the discount plan(s) and any possible conflicts of interest.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: | Address: | Contracts or Arrange-mentsYes No | Conflicts of InterestsYes No |  |  |
|       |            |  [ ]  [ ]  |  [ ]  [ ]  |  |
|       |            |  [ ]  [ ]  |  [ ]  [ ]  |
|       |            |  [ ]  [ ]  |  [ ]  [ ]  |
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|       |            |  [ ]  [ ]  |  [ ]  [ ]  |
|       |            |  [ ]  [ ]  |  [ ]  [ ]  |

3.b. If not different, when did the discount plan(s) provide the detailed disclosure?