**Section 2014.EXHIBIT A Small Group Reporting Format**

***This report shall be mailed and postmarked no later than January 31 to*:**

**Illinois Department of Insurance**

**Cost Containment Section**

**320 West Washington**

**Springfield, Illinois 62767**

**Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Report for the period ending December 31, 19\_\_\_**

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| --- | --- | --- | --- |
| (A)Number of SmallEmployer GroupPolicies in Forceas of 12/31(PreviousCalendar Year)\* | (B)Number of In-sureds, *including**dependents*, cov-ered by Em-ployer GroupPolicies shown inColumn (A) | (C)Description of benefits providedby policies issued to Small Em-ployer Groups shown in Column(A). *Description must include at**least the information appearing**below.* | (D)Policy FormNumbers as-signed by thecompany forSmall Em-ployer Grouppolicies asfiled with andapproved bythe Director |
|  |  | *Per person deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Maximum Benefit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Coinsurance* *Factors (e.g., 80/20): \_\_\_\_\_\_\_\_\_\_\_\_**Semi-private room* *rate (if based on other* *than above* c*oinsurance factor):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_*Are benefits subject to* *Third Party* *Review? (Y/N) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |
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| **\*Of these**, indicate thenumber of policieswhich replaced otherhealth insurance inforce. If none, enter'0'. |  |  |
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