MISSISSIPPI
Department of Insurance

GEORGE DALE
Commissioner

CHARLES D. PACE
Deputy Commissioner

1804 Walter Sillers Bldg.
Post Office Box 79
Jackson, Mississippi 39205-0079
#91-2181

BULLETIN BULLETIN BULLETIN

TO: All Health and Accident Insurers June 7, 1991

FROM: Commissioner of Insurance George Dale

RE: HB 563

The Mississippi Legislature has enacted a Comprehensive Health Insurance Risk Pool Association which became effective with the passage of the bill in the 1991 session of the Legislature.

This bulletin will serve as notice to all health and accident insurance companies that the association is operational and a Board has been appointed. In its first organizational meeting, held June 4, 1991, the Board requested the Mississippi Insurance Department to collect the initial assessment of $100.00, as provided in Section 7 (d) of the new law.

It reads: "... the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessment. Organizational assessments shall be equal in amount for all insurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer."

You are requested to complete the attached questionnaire so we may compile information for operational purposes. Please mail to Ronald Hanna of my staff at the above address. If you have any questions regarding these matters, please submit in writing to Mr. Hanna so the Board may review and respond at their next meeting.

Your cooperation and attention to this matter is appreciated.

ALL CHECKS MUST BE PAYABLE TO: MISSISSIPPI HEALTH POOL ASSOC.

MISSISSIPPI

MAIL ADDRESS:
MISSISSIPPI INSURANCE DEPT.
550 HIGH STREET
1806 SILLERS BLDG. (39201)
P. O. BOX 79 (39205)
JACKSON, MS

HEALTH QUESTIONNAIRE TO IMPLEMENT HB 563

THE COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION FOR THE STATE OF MISSISSIPPI

Name of Insurance Company: _____

Mail Address: _____

City: _____

Name and Title of Contact Person: _____

Telephone Number: _____

I. Please provide the following information: (Note: This form must be completed for each insurance company and figures should not be combined with affiliate companies.)

A. The number of persons insured directly by your company for health insurance either on a group or individual basis as of May 1, 1991 _____

B. The number of persons you reinsure _____

C. A list of all Third Party Administrators, including names, addresses, and telephone numbers, which have contracted with your company for reinsurance/excess coverage of self-insured programs (TPA's are defined as any entity who is paying or processing health insurance claims for any Mississippi resident).