

NEW JERSEY MEDIGARE SUPPLEMENT UNDER 50 PLAN CARRIER MARKET SHARE REPORT

2008

This Report must be completed in accordance with the provisions of N.J.A.C. 11:4-23A et seq. and certified to by a duly authorized officer of the Carrier. Reports must be completed and returned on or before March 1 annually. *If you have any questions regarding completion of this form, please call 1-800-628-7734.* Completed Reports for the calendar year 2006 are to be returned to:

**New Jersey Medicare Supplement Under 50 Plan
c/o Pool Administrators Inc.
100 Great Meadow Road, Suite 704
Wethersfield, CT 06109**

PART A. CARRIER INFORMATION

1. Carrier Name: _____
2. Carrier Address: _____

3. NAIC # (including Group #): _____
4. Is the specifically-named carrier an Affiliated Carrier: _____ yes _____ no
 - a. If Yes, is this Report the combined report for all Affiliated Carriers, or for the specifically Named Carrier?
_____ All Affiliated Carriers' Combined Report
_____ Specifically Named Carrier's Separate Report
 - b. If for all Affiliated Carriers, list the affiliated carriers and attach specifically named Carrier Reports to this Combined Report
 1. _____
 2. _____
 3. _____

PART B. PERSONAL RESPONDENT INFORMATION

- 1. Name: *(Print or Type)*: _____
- 2. Title: _____
- 3. Telephone No. _____ Fax No. _____
- 4. E Mail Address _____

PART C. CERTIFICATION

I certify that the information provided in the attached Report is accurate and complete and has been prepared in accordance with the provision of N.J.A.C. 11:4-23A et seq.

Signature of Officer

Name & Title

Date

ALL CARRIERS LICENSED IN THE STATE OF NEW JERSEY MUST COMPLETE THIS FILING IN ITS ENTIRETY. IF THERE ARE ZERO PREMIUMS TO REPORT, PLEASE INDICATE “NONE” OR “ZERO” ON THE GRID PAGE (Page 3 of 3)

THANK YOU