

EXHIBIT B

SPECIFIED DISEASE/CRITICAL ILLNESS POLICY
CALENDAR YEAR EXPERIENCE DATA

CARRIER NAME _____ NAME OF PERSON COMPLETING FORM _____

ADDRESS _____

TITLE _____ PHONE _____

POLICY FORM NO.* _____ DATE _____

DATE POLICY FILED BY NJ _____ ORIGINAL ANTICIPATED LOSS RATIO _____

YEARNATIONWIDE DATANEW JERSEY DATA

	# of Policies In Force	Paid Premium	Paid Claims	Loss Ratio	# of Policies in Force	Paid Premium	Paid Claims	Loss Ratio
[2000]
2001								
2002								
2003								
2004								
2005								
2006								
2007								
2008								
2009								
*2010								*

*Complete one report for each policy form for which policies issued in New Jersey remain inforce.

Return completed reports to:

New Jersey Department of Banking and Insurance
Health Insurance Bureau
P.O. Box 470
Trenton, NJ 08625