Health Insurance Affordability Fund Assessment
Premium Report
Reporting Year ____

Part A. Carrier Information

Carrier's Name:	
Carrier's NAIC Number:	

Note: Affiliated Carriers shall submit separate reports for each affiliate.

Part B. Personal Respondent Information

Name:	
Title:	
Phone:	
Fax:	
Email:	
Mailing Address:	

Note: The assessment invoice will be sent to the email and/or mailing address provided in this section.

Part C. Reporting Year Information

Type of Insurance	Direct Written Premium (SHCE Part 2, Line 1.1, or equivalent form)
Individual Health Coverage	$
Large Group Health Benefits	$
Dental	$
Vision	$

Part D. Certification

I certify that I am the Chief Financial Officer or other duly authorized officer of the company and that the information provided in this Report is accurate and complete, and has been prepared in accordance with the provisions of N.J.S.A. 17B:27A-66.

Printed Name:	
Title:	
Signature:	Date:

Note: Electronic signatures are acceptable.

This report must be completed in accordance with the provisions of N.J.S.A. 17B:27A-66, and certified by the Chief Financial Officer or other duly authorized officer of the Carrier.

The source of data for determining direct premiums written is the Supplemental Health Care Exhibit (SHCE), filed with the NAIC, or any equivalent form required by state or federal law. If the Carrier does not file an SHCE, the Carrier is still required to file a Health Insurance Affordability Fund Assessment Premium Report and provide direct premiums written.

References to the SHCE in these instructions are solely for your convenience in identifying the premium information required for this report and are subject to change.

This report must be completed and returned to lifehealth@dobi.nj.gov by April 1 of the year immediately following the reporting year.