|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NEW JERSEY MEDICARE SUPPLEMENT UNDER 50 PLAN** | | | | | | | | | | | |
| **CARRIER MARKET SHARE REPORT** | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| **2021**  **Due on or before April 1, 2022** | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| This report must be completed in accordance with the provisions of N.J.A.C. 11:4-23A et seq., by all carriers licensed | | | | | | | | | | | |
| in the state of New Jersey, and certified to by a duly authorized officer of the Carrier. | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| Reports must be completed **ONLY** if Total Direct Premiums Earned on the calculation page exceeds zero. | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| Completed reports for the calendar yearare to be returned to: | | | | | | | |  | |  |  |
|  | |  |  |  |  |  |  |  | |  |  |
| New Jersey Medicare Supplement Under 50 Plan | | | | | | | | | | | |
| Attn: Rosaria Lenox | | | | | | | | | | | |
| PO Box 325 | | | | | | | | | | | |
| Trenton, NJ 08625-0325 | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| or by email to: rosaria.lenox@dobi.nj.gov | | | | | | | | | | | |
| (Note: It is not necessary to send by mail and email) | | | | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
| **PART A. CARRIER INFORMATION** | | | | |  |  |  |  | |  |  |
|  | | 1. Carrier Name: | |  | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
|  | | 2. Carrier Address: | |  | | | | | | | |
|  | |  |  |  | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
|  | | 3. NAIC # (including Group #): | | |  | | |  | |  |  |
|  | |  |  |  |  |  |  |  | |  |  |
|  | |  |  |  |  |  |  |  | |  |  |
| **PART B. PERSONAL RESPONDENT INFORMATION** | | | | | |  |  |  | |  |  |
|  | | 1. Name: |  | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
|  | | 2. Title: |  | | | | | | | | |
|  | |  |  |  |  |  |  |  | |  |  |
|  | | 3. Telephone No. | |  | | | FAX No. |  | | | |
|  | |  |  |  |  |  |  |  | |  |  |
|  | | 4. Email 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** | |  |  |  |  |  |  |  | |  |  |
|  | **NEW JERSEY MEDICARE SUPPLEMENT UNDER 50** | | | | | | | | | | | |
|  | **MARKET SHARE REPORT** | | | | | | | | | | | |
|  | **Carrier Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NAIC# \_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | |  | | | |
|  | **Section1:** | | | | | | | |  | | | |
|  | **Total Accident and Health DIRECT PREMIUMS EARNED as reported on the Annual Statement to the New Jersey Department of Banking & Insurance** | | | | | | | |  | | | |
|  | **Life Companies (page 24, Column 2, line 26)** | | | | | | | | **$** | | | |
|  | **Health Companies (Page 30, Column 1, line 15)** | | | | | | | | **$** | | | |
|  | **Fraternal Companies (Page 23, Column 3, line 26)** | | | | | | | | **$** | | | |
|  | **Property & Casualty Companies (Page 19, Column 2, lines 13,14,15.1-15.4, 15.6, 15.7)** | | | | | | | | **$** | | | |
|  | **TOTAL DIRECT PREMIUMS EARNED (If the sum equals zero, this report is NOT required to be filed)** | | | | | | | | **$** | | | |
|  | **Section 2: List of Excepted Benefits and Premium** | | | | | | | |  | | | |
| a. | Medicare Advantage and Medicare + Choice coverage and Medicare Demonstration and Medicare Part D Coverage | | | | | | | | $ | | | |
| b. | contracts funded pursuant to the "Federal Employee Health Benefits Act of 1959," 5 U.S.C. § § 8901‑8914 | | | | | | | | $ | | | |
| c. | excess risk or stop loss insurance coverage issued by a carrier in connection with any self insured health benefits plan | | | | | | | | $ | | | |
| d. | non-expense incurred specified disease coverage | | | | | | | | $ | | | |
| e. | coverage only for accident, disability income insurance, or any combination | | | | | | | | $ | | | |
| f. | coverage issued as a supplement to liability insurance | | | | | | | | $ | | | |
| g. | liability insurance, including general liability insurance and automobile liability insurance | | | | | | | | $ | | | |
| h. | workers' compensation or similar insurance | | | | | | | | $ | | | |
| i. | automobile medical payment insurance | | | | | | | | $ | | | |
| j. | credit‑only insurance | | | | | | | | $ | | | |
| k. | coverage for on‑ site medical clinics | | | | | | | | $ | | | |
| l. | other similar insurance coverage, as specified in federal regs., under which benefits for medical care are secondary or incidental to other insurance benefits | | | | | | | | $ | | | |
| m. | limited scope dental or vision benefits\* | | | | | | | | $ | | | |
| n. | benefits for long‑term care, nursing home care, home health care, community‑based care, or any combination thereof if coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan | | | | | | | | $ | | | |
| o. | such other similar, limited benefits as are specified in federal regulations if coverage is provided under a separate policy, certificate or contract of insurance or is otherwise not an integral part of the plan | | | | | | | | $ | | | |
| p. | hospital confinement indemnity coverage if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health benefits plan maintained by the same plan sponsor, and those benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor | | | | | | | | $ | | | |
| q. | coverage supplemental to the coverage provided under chapter 55 of Title 10, United States Code (10 U.S.C. § 1071 et seq.) | | | | | | | | $ | | | |
| r. | similar supplemental coverage provided to coverage under a group health plan | | | | | | | | $ | | | |
|  | **Total excepted premium:** | | | | | | | | $ | | | |
|  | **Section 3: "Net Earned Premium" (Total from Section 1 minus Total from Section 2)** | | | | | | | | **$** | | | |