

Medicare Supplement Insurance Regulation

APPENDIX B

FORM FOR REPORTING  
MEDICARE SUPPLEMENT POLICIES

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and  
Certificate #

Date of  
Issuance

Policy and Certificate #	Date of Issuance

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name and Title (please type)

\_\_\_\_\_  
Date