

**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 No.	Date of Issuance

Signature

Name - (Please Type)

Title - (Please Type)

Date