OFFICE of the INSURANCE COMMISSIONER
WASHINGTON STATE

# COMPANY SUPERVISION DIVISION
# 2019 Annual Report for a Licensed Health Carrier Doing Business as a Discount Plan(s)
### For the year ending December 31, 2019

| Legal Name of Licensed Health Carrier | | WAOIC No. |
|---|---|---|
| <Enter name here> | | |

This Annual Report is to be filed **on or before March 31, 2020** in compliance with RCW 48.155.015(2)(b). Failure to complete this Annual Report as prescribed will subject the health carrier to possible disciplinary action.

1. All pages must be completely filled out.
2. The Annual Report may be filled out using Microsoft WORD.
3. Page 2 of the report must be printed, hand-signed, and notarized.
   *Electronic signatures are not acceptable.*

Per WAC 284-155-030(3):
The Annual Report must be converted to a PDF file format prior to upload.

Upload to our filing portal at:
https://fortress.wa.gov/oic/onlineservices/Login.aspx?module=FIN

**See RCW 48.155.110 regarding the $20 annual reporting fee requirement.**
Fee payment: Send your check along with this page (to serve as the backup documentation) to the appropriate address noted below:

**U.S. Mail**: Washington State Office of Insurance Commissioner
Attention: Company Supervision,
P. O. Box 40255,
Olympia, WA 98504-0255

**Hand Delivery**: Washington State Office of Insurance Commissioner
Attention: Company Supervision,
5000 Capitol Boulevard SE,
Tumwater, WA 98501

Do not alter or modify the preprinted language on this form. Please contact Sarah Froyland at (360) 725-7205 or CompanySupervisionFilings@oic.wa.gov if you have any questions regarding this Annual Report.

ANNUAL REPORT
For the Year Ended December 31, 2019
OF THE CONDITION AND THE AFFAIRS OF

_____
(Name of Licensed Health Carrier)
Organized under the Laws of the State of _____, made to the
INSURANCE COMMISSIONER OF THE STATE OF WASHINGTON
PURSUANT TO THE LAWS THEREOF

Mail Address: _____

Primary Location of
Books and Records: _____

Discount Plan Annual Report Contact
Person and Phone Number: _____
E-Mail Address: _____

Compliance Officer Responsible for Ensuring Compliance with Chapter
48.155 RCW and Phone Number: _____
E-Mail Address: _____

State of _____

County of _____

_____ being duly sworn, says that this annual report is an accurate and true statement of the affairs of said health carrier's discount plan business.

Signature: _____

Title: _____

Subscribed and sworn to before me this
_____ day of _____, 2020

_____
Notary Public
My Commission expires _____



Without a notarized signature this Report is incomplete and out of compliance with RCW 48.155.050(3)(b)

1. Please provide detail for all Washington discount plan transactions for the year ending December 31, 2019 in the table below:

| Entity | Funds Received | Funds Disbursed |
|---|---|---|
| Aggregate for All WA Members | $ | $ |
| Aggregate for All WA Prospective Members | $ | $ |
| Aggregate for All WA Individual Providers | $ | $ |
| Detail for All WA Provider Networks Identified by Network Name: | | |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |
| | $ | $ |

2.a. Please provide the number of members the discount plan(s) has (have) in Washington as of December 31, 2019:

2.b. Please provide the total number of members the discount plan(s) has (have) as of December 31, 2019:

3.a. If different from the most recent disclosure provided in previous Annual Report, please provide the names and resident addresses of all persons responsible for conduct of the discount plan's affairs, and whether or not any of these people have or had any contracts or arrangements with the discount plan(s) and any possible conflicts of interest.

| Name: | Address: | Contracts or Arrangements<br>Yes No | Conflicts of Interests<br>Yes No |
|---|---|---|---|
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |
| | | ☐ ☐ | ☐ ☐ |

3.b. If not different, when did the discount plan(s) provide the detailed disclosure?