**Section 2014.EXHIBIT A Small Group Reporting Format**

***This report shall be mailed and postmarked no later than January 31 to*:**

**Illinois Department of Insurance**

**Cost Containment Section**

**320 West Washington**

**Springfield, Illinois 62767**

**Company Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Report for the period ending December 31, 19\_\_\_**

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| --- | --- | --- | --- |
| (A)  Number of Small  Employer Group  Policies in Force  as of 12/31  (Previous  Calendar Year)\* | (B)  Number of In-  sureds, *including*  *dependents*, cov-  ered by Em-  ployer Group  Policies shown in  Column (A) | (C)  Description of benefits provided  by policies issued to Small Em-  ployer Groups shown in Column  (A). *Description must include at*  *least the information appearing*  *below.* | (D)  Policy Form  Numbers as-  signed by the  company for  Small Em-  ployer Group  policies as  filed with and  approved by  the Director |
|  |  | *Per person deductible:\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Maximum Benefit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *Coinsurance*  *Factors (e.g., 80/20): \_\_\_\_\_\_\_\_\_\_\_\_*  *Semi-private room*  *rate (if based on other*  *than above*  c*oinsurance factor):*\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Are benefits subject to*  *Third Party*  *Review? (Y/N) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |
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| **\*Of these**, indicate the  number of policies  which replaced other  health insurance in  force. If none, enter  '0'. | |  |  |
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