SURVEY FOR IOWA COMPREHENSIVE HEALTH ASSOCIATION

For the Year Ending: December 31, 2024

INSTRUCTIONS:

Pursuant to Iowa Code Chapter 514E, the net losses of the Iowa Comprehensive Health Association shall be assessed to members. To ensure that this assessment is made on an equitable basis, you are required to complete this supplemental form and return it to the address provided below every year, even if your company had no premium to report for the calendar year indicated. The survey shall be submitted no later than **May 15, 2025.**

COMPANY INFORMATION

NAIC#: _____

Company Name: _____

Contact Address: _____

- **City** _____
- **State**: _____
- **Zip**: _____

Contact Person: _____

Contact Phone: _____

Contact Email Address: _____

Billing Information (if different):

Billing Address: _____

- **City**: _____
- **State**: _____
- **Zip**: _____

Billing Contact Name: _____

Billing Contact Phone: _____

Billing Email Address: _____

PREMIUM INFORMATION

Indicate **NONE** in any section that does not apply to your organization. Please provide premium information for the following lines of business:

Lines of Business for Reporting Premium:

13.1 Comprehensive (hospital and medical) individual: $_____

13.2 Comprehensive (hospital and medical) group: $_____

14 Credit A&H (group and individual): $_____

15.1 Vision only: $_____

15.2 Dental only: $_____

15.3 Disability income: $_____

15.4 Medicare Supplement: $_____

15.5 Medicaid Title XIX: $_____

15.6 Medicare Title XVII: $_____

15.7 Long-Term Care: $_____

15.8 Federal Employees health benefits plan premium: $_____

15.9 Other Health: $_____

Total Iowa Direct Premiums Earned or Subscriber Charges from lines of business above based on carrier type.

Life Companies $_____

P & C Companies $_____

Health Companies $_____

Deductions

Less the following deductions (only if included in the premiums earned above):

- Coverage only for a specified disease or illness $_____
- Medicare Cost Reimbursement (HMO) $_____
- Medicare Risk $_____
- Medicare Part D $_____
- Medicare Supplement $_____
- Federal Employee Health Benefit Plan $_____
- HMO dues from outside Iowa $_____
- Coverage issued as a supplement to liability insurance $_____
- Worker's compensation or similar insurance $_____
- Accident only or disability income insurance $_____
- A short term limited duration insurance policy $_____
- Automobile/Homeowner medical payment insurance $_____
- Credit only insurance $_____
- Limited scope dental and vision issued under a separate policy $_____
- Benefits for long term care, nursing home care, home health care, or community-based care issued under a separate policy $_____
- Hospital Indemnity and fixed indemnity insurance $_____
- Liability insurance, including general liability and auto liability $_____
- Medicaid $_____
- Hawk-I $_____

Total Deductions: $_____

2024 ICHA Assessment Base

(Total Premiums less Total Deductions): $_____

CERTIFICATION

I hereby certify that, to the best of my knowledge and belief, that the information set out in the 2024 Survey for Iowa Comprehensive Health Association is true and correct. I understand that adjustments to these figures will not be allowed.

Signature of Officer: _____

Title: _____

Date: _____

QUESTIONS

If you have any questions regarding this form, please contact Kris Matherly:

- **Phone**: (806) 698-5821
- **Email**: Kris.Matherly@90degreebenefits.com

MAILING ADDRESS

Please return the completed form by **May 15, 2025** to:

riskpoolaccounting.t8@90degreebenefits.com

Or mail to:

Iowa Comprehensive Health Association
Attn: Assessment & Survey Division
3307 82nd Street
Suite 37
Lubbock, TX 79423
