Wisconsin Office of the COMMISSIONER OF INSURANCE

CERTIFICATION OF MANAGED CARE PLAN TYPE

Name of Insurer

I hereby certify that, as an officer of the above company, I have authority to bind and obligate the company by filing this certification. I further certify, pursuant to s. Ins 9.40 (8), Wis. Adm. Code, that, to the best of my knowledge, information and belief, the company offers, insures, or actively markets, the following types of managed care plans.

List the product name, policy form number, and plan type of each managed care plan you offer, insure, or actively market. Attach to this certification an outline of coverage or summary description for each policy form listed.

Product Name	**Policy Form Number**	**Plan Type** (choose appropriate number from 1-7 below)

(Use separate sheet if additional space is required.)

Plan Types

1. HMO (Health Maintenance Organization) as defined by s. 609.01 (2), Wis. Stat.
2. HMO/POS (Health Maintenance Organization/Point of Service Plan)
3. PPO (Preferred Provider Plan) as defined by s. 609.01 (4), Wis. Stat.
4. LSHO (Limited Service Health Plan) as defined by s. 609.01 (3), Wis. Stat.
5. A plan where the only insurer owned, employed, or participating providers providing services covered under the plan, meet the definition of a silent provider network as defined by s. Ins 9.01 (17), Wis. Adm. Code.
6. A plan where covered services are provided by insurer owned, employed, or participating providers that meet the definition of a silent provider network as defined by s. Ins 9.01 (17), Wis. Adm. Code, as well as by insurer owned, employed, or participating providers who are not a silent provider network.
7. A plan that meets the de minimus limited exception requirements in s. Ins 9.32 (2), Wis. Adm. Code.

Name and T tle	Date
Insurer Address	Phone Number

Pursuant to s. 601.72, Wis. Stats. Personal information you provide may be used for purposes other than that for which it was originally collected (s. 15.04(1)(m),Wis. Stats.)

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