

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 9.32, Wis. Adm. Code, that, to the best of my knowledge, information and belief, the company, for the preceding year, complied with the access standards of s. Ins 9.32, Wis. Adm. Code, and s. 609.22, Wis. Stat., and that:

1. The company's managed care plans provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation, waiting times for appointments in provider offices and after hours care.
2. The company's managed care plans have sufficient number and type of plan providers to adequately deliver all covered services based on the demographics and health status of current and expected enrollees served by the plan.
3. The company's managed care plans provide emergency medical services as a covered benefit when the enrollee receives treatment for an emergency medical condition, as defined by s. 632.85, Wis. Stat., from a nonparticipating provider.

Name and Title	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.)