Attn: Keith V. Taylor
Director, Health Coverage Tax Credit
1111 Constitution Ave, N.W.
W:HCTC/CNN 750
Washington, D.C. 20224

Dear Mr. Taylor:

Below are the details regarding the qualified health insurance options the state of <*State name*> has chosen to make available to eligible participants under the tax credit:

a. State official responsible for implementing this decision:

   Name: _____
   Title: _____
   Address: _____
   _____
   City:_____ State: _____ ZIP: _____
   Telephone Number: _____

b. Option number *(enter option 2-8):* _____
c. Name of the option: _____
d. Policy number or unique identifier of the option: _____
e. Name and telephone number for the plan administrator or insurance carrier official who can provide additional information:

   Name: _____
   Telephone Number: _____

f. Certify that the following four requirements met for each plan under this option. (Please enter a response of either "**Yes**" or "**No**" on the lines provided):
   i. Guaranteed issue: Qualifying individuals must be guaranteed enrollment regardless of their medical status and must be permitted to remain enrolled so long as they pay the premium: _____

ii. No pre-existing condition restrictions: No pre-existing condition restriction may be imposed on qualifying individual: _____
iii. Nondiscriminatory premium: The premium charged for a qualifying individual may not be greater than the premium for a similarly situated person who is not receiving the credit: _____
iv. Benefits are the same (or substantially the same) under coverage provided to similarly situated individuals who are not qualifying individuals: _____

If you or any of your staff have any questions, please contact the following individual:

Name: _____
Title: _____
Address: _____
_____
City:_____ State: _____ ZIP: _____
Telephone Number: _____

Sincerely,