CERTIFICATION OF HEALTH PLAN CONSUMER REPORT

Submitted To
STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
State Center for Health Statistics
2727 Mahan Drive
Fort Knox, Building #3, Mail Stop 16
Tallahassee, Florida 32308-5403

From

(Name of Health Insurer)	(Florida Company Code)
(Street Address)	(NAIC Company Code)
(City and Zip Code)	(Telephone Number)

I have examined the Health Plan Consumer Report required by rules 59B-14.001 – 59B-14.008 of the Florida Administrative Code for the time period indicated below, and to the best of my knowledge and belief, the information contained in this report is true, accurate, and complete, and prepared according to the NCQA CAHPS survey specifications from the books and records of this firm, except as noted.

Report period:

____/____/____ TO____/____/____ (MM/DD/YYYY)

NAME OF CHIEF FINANCIAL OFFICER OR DULY AUTHORIZED REPRESENTATIVE: _____

OFFICIAL TITLE: _____

SIGNATURE: _____

DATE: _____

NAME OF EMPLOYEE CONTACT: _____

OFFICIAL TITLE: _____

SIGNATURE: _____

DATE: _____

SIGNATURES OF BOTH PERSONNEL ABOVE ARE REQUIRED

HPCR-1 (6/1/2005)