Reset Form

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

POLICY VERIFICATION
MULTIPLE EMPLOYER WELFARE ARRANGEMENT

The following information is to be completed by an officer or director of the insurer, health maintenance organization, health services plan, or dental or optometric services plan issuing coverage to a multiple employer welfare arrangement:

_____
NAIC Number

_____
Full and Exact Name of Insurance Company

_____
Mailing Address

I hereby certify that the above named insurer, health maintenance organization, health services plan, or dental or optometric services plan has issued a contract of insurance on a direct basis as defined in the Commissions Rules Governing Multiple Employer Welfare Arrangements (14 VAC 5-410-10 et seq.) to the following Multiple Employer Welfare Arrangement:

_____
Name of Multiple Employer Welfare Arrangement

I further certify that the Company I represent is licensed and in good standing to transact the business of insurance in the Commonwealth of Virginia.

Please list below all policies providing coverage for health care services currently issued or in force fully insuring this MEWA. Additional pages may be attached to this form if necessary.

Policy Number	Effective Date	Expiration Date

Dated at _____ this _____ day of _____, 20_____

_____ _____
(Signature of Company Officer or Director) (Title)

Subscribed before me this _____ day of _____, 20_____

(Notary Seal) _____
(Notary Public)

My commission expires: _____