APPENDIX BB. WRITTEN CONFIRMATION STATEMENT

I confirm, on behalf of _____[organization]_____, that:

- information to be disclosed to us will be subject to confidentiality provisions equivalent to the professional confidentiality mandate set forth in Part 15 of Subchapter 7 of Chapter 25 of Title 365 of the Oklahoma Administrative Code; and

- we will notify all signatories to this agreement and any supervisory organization composed of Regulators of any changes in the guarantees of professional confidentiality applied to such information which could affect the assessment of the equivalence of these guarantees according to the confidentiality regime set forth in this Regulation.

I also confirm, on behalf of my organization, that in relation to information disclosed by another Regulator:

- we will obtain the prior consent of the Regulator from whom the information originated before voluntarily passing on such information to another Regulator; and

- we will, as far as practicable, promptly notify the originating Regulator of any passing on of information or disclosure prescribed by law, and use our best efforts to resist such demand in practice if so requested by that originating Regulator.

__[ORGANIZATION]_____

Signature_____

Name:_____

Title:_____

Date:_____

APPENDIX CC. CERTIFICATE OF CERTIFIED REINSURER [NEW]
FORM CR-1

CERTIFICATE OF CERTIFIED REINSURER

I, _____, _____
(name of officer) (title of officer)

of _____, the assuming insurer
(name of assuming insurer)
under a reinsurance agreement with one or more insurers domiciled in

_____, in order to be considered for approval in this state, hereby certify that (name of state)

_____("Assuming Insurer"):
(name of assuming insurer)

1. Submits to the jurisdiction of any court of competent jurisdiction in _____
(ceding insurer's state of domicile)
for the adjudication of any issues arising out of the reinsurance agreement, agrees to comply with all requirements necessary to give such court jurisdiction, and will abide by the final decision of such court or any appellate court in the event of an appeal. Nothing in this paragraph constitutes or should be understood to constitute a waiver of Assuming Insurer's rights to commence an action in any court of competent jurisdiction in the United States, to remove an action to a United States District Court, or to seek a transfer of a case to another court as permitted by the laws of the United States or of any state in the United States. This paragraph is not intended to conflict with or override the obligation of the parties to the reinsurance agreement to arbitrate their disputes if such an obligation is created in the agreement.

2. Designates the Insurance Commissioner of _____
(ceding insurer's state of domicile)
as its lawful attorney upon whom may be served any lawful process in any action, suit or proceeding arising out of the reinsurance agreement instituted by or on behalf of the ceding insurer.

3. Agrees to provide security in an amount equal to 100% of liabilities attributable to U.S. ceding insurers if it resists enforcement of a final U.S. judgment or properly enforceable arbitration award.

4. Agrees to provide notification within 10 days of any regulatory actions taken against it, any change in the provisions of its domiciliary license or any change in its rating by an approved rating agency, including a statement describing such changes and the reasons therefore.

5. Agrees to annually file information comparable to relevant provisions of the NAIC financial statement for use by insurance markets in accordance with 365:25-7-73.

6. Agrees to annually file the report of the independent auditor on the financial statements of the insurance enterprise.

7. Agrees to annually file audited financial statements, regulatory filings, and actuarial opinion in accordance with 365:25-7-73.

8. Agrees to annually file an updated list of all disputed and overdue reinsurance claims regarding reinsurance assumed from U.S. domestic ceding insurers.

9. Is in good standing as an insurer or reinsurer with the supervisor of its domiciliary jurisdiction.

Dated: _____ _____

(name of assuming insurer)

BY: _____

(name of officer)

_____

(title of officer)

APPENDIX DD. ANNUAL REINSURANCE REVIEW – PROPERTY & CASUALTY INSURERS [NEW]

Form CR-F – PART 1

Assumed Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	Reinsurance On			9	10	11	12	13	14	15
					6	7	8							
Company Code or ID Number		Name of Reinsured	Domiciliary Jurisdiction	Assumed Premium	Paid Losses and Loss Adjustment Expenses	Known Case Losses and LAE	Cols. 6 + 7	Contingent Commissions Payable	Assumed Premiums Receivable	Unearned Premium	Funds Held By or Deposited With Reinsured Companies	Letters of Credit Posted	Amount of Assets Pledged or Compensating Balances to Secure Letters of Credit	Amount of Assets Pledged or Collateral Held in Trust
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9999999 Totals														

Form CR-F – PART 2

Ceded Reinsurance as of December 31, Current Year (000 Omitted)

1	2	3	4	5	6	Reinsurance Recoverable On									Reinsurance Payable		18	19
						7	8	9	10	11	12	13	14	15	16	17		
Company Code or ID Number		Name of Reinsurer	Domiciliary Jurisdiction	Reinsurance Contracts Ceding 75% or More of Direct Premiums Written	Reinsurance Premiums Ceded	Paid Losses	Paid LAE	Known Case Loss Reserves	Known Case LAE Reserves	IBNR Loss Reserves	IBNR LAE Reserves	Unearned Premiums	Contingent Commissions	Cols. 7 through 14 Totals	Ceded Balances Payable	Other Amounts Due to Reinsurers	Net Amount Recoverable From Reinsurers Cols. 15 – [16 + 17]	Funds Held by Company Under Reinsurance Treaties
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9999999 Totals																		

APPENDIX EE. ANNUAL REINSURANCE REVIEW – LIFE & HEALTH INSURERS [NEW]

Form CR-S – PART 1 – SECTION 1

Reinsurance Assumed Life Insurance, Annuities, Deposit Funds and Other Liabilities
Without Life or Disability Contingencies, and Related Benefits Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Location	6 Type of Reinsurance Assumed	7 Amount of In Force at End of Year	8 Reserve	9 Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 1 – SECTION 2

Reinsurance Assumed Accident and Health Insurance Listed by Reinsured Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Reinsured	5 Domiciliary Jurisdiction	6 Type of Reinsurance Assumed	7 Premiums	8 Unearned Premiums	9 Reserve Liability Other Than For Unearned Premiums	10 Reinsurance Payable on Paid and Unpaid Losses	11 Modified Coinsurance Reserve	12 Funds Withheld Under Coinsurance
Totals											

Form CR-S – PART 2

Reinsurance Recoverable on Paid and Unpaid Losses Listed by Reinsuring Company as of December 31, Current Year

1 Company Code or ID Number	2	3 Effective Date	4 Name of Company	5 Location	6 Paid Losses	7 Unpaid Losses
Totals—Life, Annuity and Accident and Health						

Form CR-S – PART 3 – SECTION 1

Reinsurance Ceded Life Insurance, Annuities, Deposit Funds and Other Liabilities

Without Life or Disability Contingencies, and Related Benefits Listed by Reinsuring Company as of December 31, Current Year

1	2	3	4	5	6	7	Reserve Credit Taken		10	Outstanding Surplus Relief		13	14
Company Code or ID Number		Effective Date	Name of Company	Location	Type of Reinsurance Ceded	Amount in Force at End of Year	8 Current Year	9 Prior Year	Premiums	11 Current Year	12 Prior Year	Modified Coinsurance Reserve	Funds Withheld Under Coinsurance
Totals													

Form CR-S – PART 3 – SECTION 2

Reinsurance Ceded Accident and Health Insurance Listed by Reinsuring Company as of December 31, Current Year

1	2	3	4	5	6	7	8	9	Outstanding Surplus Relief		12	13
Company Code or ID Number		Effective Date	Name of Company	Location	Type	Premiums	Unearned Premiums (Estimated)	Reserve Credit Taken Other than for Unearned Premiums	10 Current Year	11 Prior Year	Modified Coinsurance Reserve	Funds Withheld Under Coinsurance
Totals												

APPENDIX FF. SMALL EMPLOYER STOP LOSS DISCLOSURE [NEW]

Date Prepared:_____

Insurer Name: _____

Plan Sponsor/Employer: _____

Policy ID/#: _____

Policyholder: _____

Plan Name: _____

Policy Effective Date: _____

Policy Expiration Date: _____

Plan expenses are eligible if incurred from _____ to _____

Plan expenses are eligible if paid from _____ to _____

Individual Attachment Point for Specific Coverage: _____

This Policy [does] [does not] (circle one) have different Individual Attachment Point(s) for certain individuals or conditions.

If it does, describe:

_____

_____

Aggregate Attachment Point: _____

Producer: _____

Important Policyholder/Plan Sponsor Information:

You have purchased a policy that provides reimbursement to you for losses of your self-funded health Plan identified above, subject to the terms and conditions of your Policy.

Your Policy is not a policy that pays for the direct medical expenses incurred by your employees or the beneficiaries of your Plan. Your Policy is NOT A GROUP OR INDIVIDUAL medical insurance policy offering health insurance benefits. You are responsible for payment of your employees' claims covered by your self-funded health Plan.

The insurer issuing this Policy is not responsible for the payment of the benefits provided by your Plan. The insurer is only responsible for reimbursing you for covered claims which you have paid as provided by the Policy.

Self-funding an employer medical benefit plan may subject you to financial obligations and regulatory requirements that are not present when you purchase a group health insurance policy. YOU SHOULD CONSULT WITH A QUALIFIED ACTUARY, PRODUCER, CONSULTANT, OR ATTORNEY REGARDING YOUR OBLIGATIONS AS A SELF-FUNDED PLAN SPONSOR, and YOUR SELECTION OF STOP LOSS POLICY TERMS.

This disclosure is provided as required by Section 7401 of Title 36 of the Oklahoma Statutes, and is for your information only. In the event of a conflict between this disclosure and your Policy, the terms and conditions of your Policy will apply.