

POS Information Form

Company Name: _____

Contact Name: _____

Contact Phone #: _____

NAIC Cocode: _____

Annual/Quarter Reporting Date: _____

Current Date: _____

POS Projected claims for most recent year-end: _____

POS Actual Claims for current quarter: _____

POS Actual Claims for current year to date: _____

Total Medical and Hospital Expenses current quarter: _____

POS Total Medical and Hospital Expenses current quarter: _____