HEALTH CARRIER EXTERNAL REVIEW ANNUAL REPORT FORM

Oklahoma Insurance Department

Health Carrier External Review Annual Report Form

<table>
<thead>
<tr>
<th>External Review Annual Summary for 20_______</th>
<th>Due by January 31 for the previous calendar year.</th>
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<tbody>
<tr>
<td>Each health carrier shall submit an annual report with information in the aggregate by State and by type of health benefit plan.</td>
<td></td>
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</tbody>
</table>

1. Health carrier name:  
2. Health carrier address:  
   City, State, Zip:  
3. Health carrier Website:  
4. Name of person completing this form:  
   Email:  
   Phone:  
   Fax:  
5. Total number of external review requests received from the Oklahoma Insurance Department during the reporting period:  
6. From the total number of external review requests provided in Question 5, the number of requests determined eligible for a full external review:  

Please submit to:  
Oklahoma Insurance Department  
Five Corporate Plaza  
3625 NW 56th Street, Suite 100  
Oklahoma City, OK 73112-4511