

EXHIBIT B

SPECIFIED DISEASE/CRITICAL ILLNESS POLICY  
CALENDAR YEAR EXPERIENCE DATA

CARRIER NAME \_\_\_\_\_ NAME OF PERSON COMPLETING FORM \_\_\_\_\_

ADDRESS \_\_\_\_\_

TITLE \_\_\_\_\_ PHONE \_\_\_\_\_

POLICY FORM NO.\* \_\_\_\_\_ DATE \_\_\_\_\_

DATE POLICY FILED BY NJ \_\_\_\_\_ ORIGINAL ANTICIPATED LOSS RATIO \_\_\_\_\_

<u>YEAR</u>	<u>NATIONWIDE DATA</u>				<u>NEW JERSEY DATA</u>			
	# of Policies In Force	Paid Premium	Paid Claims	Loss Ratio	# of Policies in Force	Paid Premium	Paid Claims	Loss Ratio

\*[2000 \_\_\_\_\_ ]\*

2001 \_\_\_\_\_

2002 \_\_\_\_\_

2003 \_\_\_\_\_

2004 \_\_\_\_\_

2005 \_\_\_\_\_

2006 \_\_\_\_\_

2007 \_\_\_\_\_

2008 \_\_\_\_\_

2009 \_\_\_\_\_

\*2010 \_\_\_\_\_ \*

\*Complete one report for each policy form for which policies issued in New Jersey remain inforce.

Return completed reports to:

New Jersey Department of Banking and Insurance  
Health Insurance Bureau  
P.O. Box 470  
Trenton, NJ 08625