



**State of New Jersey**

DEPARTMENT OF BANKING AND INSURANCE

DIVISION OF INSURANCE

OFFICE OF SOLVENCY REGULATION

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*Lt. Governor*

MARLENE CARIDE  
*Commissioner*

Annual Financial Reporting Requirements – Dental Plan Organization

The purpose of this correspondence is to standardize financial reporting for Dental Plan Organizations (DPOs) licensed in New Jersey, and to ensure that data is properly captured in order to comply with the statute and regulations. All filings must be submitted no later than the below indicated due date. **Please note that items outlined in “bold” are new and/or changes in requirements from last year’s guidelines.**

The major reporting requirements are as follows:

<u>REPORT</u>	<u>DUE DATE</u>
Annual Statement (including all supporting schedules)	March 1
Management Discussion & Analysis	March 1
Supplemental Compensation Exhibit	March 1
New Jersey Specific Annual Supplement	March 1
Risk-based Capital Calculation Report if applicable	March 1
Annual Form B/C/F	April 1
Form A/D/E	When Applicable
Audited Annual Financial Statements	June 1
Quarterly Report (1 <sup>st</sup> -3 <sup>rd</sup> Quarters only)	May 15, August 15, November 15

The report shall be completed as prescribed by the National Association of Insurance Commissioners (NAIC) Annual Statement Instructions Health that is applicable to the reporting year, and shall be completed on a statutory accounting basis (SAP) in accordance with the NAIC Accounting Practices and Procedures Manual applicable to the reporting year. Copies of the Instructions and Manual may be obtained from the NAIC Publications Department, 2301 McGee Street, Kansas City, MO 64108-2660. Telephone number: 816-783-8300. Web address [https://content.naic.org/industry\\_financial\\_filing.htm](https://content.naic.org/industry_financial_filing.htm)

DPOs shall submit the annual statement for the prior calendar year using the current format established by the National Association of Insurance Commissioners for DPOs, more commonly

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referred to as the “NAIC Health Blank.” The forms are available for purchase through several independent insurance service companies throughout the United States.

Original signatures are required on all filings. The President and Secretary, or in their absence two principal officers must sign the annual statement. All requests for exceptions from normal filings must be submitted at least 30 days prior to the due date.

Due to changes in the NAIC Data Base and the Affordable Care Act all DPOs domiciled in New Jersey should check the “Hospital, Medical & Dental Service or Indemnity” box on the Jurat Page in the section, “Licensed as business type.” DPOs not domiciled in New Jersey are to check the box as directed by their state of domicile.

All DPOs are required to complete the blanks and supplemental schedules in their entirety. If a specific schedule is not applicable to the DPO that should be so indicated using “N/A” or “None”. Any deviations from the instructions in this announcement, without the permission of the Commissioner of Banking and Insurance will be considered a violation of filing requirements and cause the entire statement filing to be rejected.

The DPO shall segregate assets into categories of “Admitted Assets” and “Non-Admitted Assets.” The Non-Admitted Assets will be excluded by the Department in considering the DPO’s minimum statutory net worth, solvency, and deposit requirements. Assets not specifically identified as an admitted asset within the Accounting Practices and Procedures Manual shall be considered Nonadmitted.

All DPOs are required to comply with the requirements of N.J.S.A. 17B:20, regarding Investments.

The Management’s Discussion and Analysis must be submitted by March 1 (not April 1 as recommended by the NAIC) each year. This supplement is primarily a narrative document setting forth information which enables the Department to enhance our understanding of the DPO’s financial position, results of operations, changes in capital and surplus accounts and cash flow. The narrative may refer to such schedules, exhibits, General Interrogatories and five-year historical data contained in the annual statement as management believes to be necessary. In addition to obvious facts which may be ascertained from the statement, please give reasons for significant changes from the previous statement. See the attached NAIC MD&A instructions for the specific format and detailed guidance.

Supplemental Compensation Exhibit (Do Not File This With The NAIC). The purpose of this Exhibit is to provide information concerning payments to senior management and directors that could negatively impact on a DPO’s financial condition. DPOs that are part of a group of insurers or other holding company system may file amounts paid to officers and employers of more than one insurer in the group or system either on a total gross basis or by allocation to each insurer. Compensation shall consist of any and all remuneration paid to or on behalf of an officer, employee, or director covered by this requirement, including, but not limited to wages, salaries, bonuses, commissions, stock grants, and gains from the exercise of stock options, and any other emolument. Part 1 consists of three interrogatories to be answered by all companies. In Part 2 you report your five most highly compensated employees. The CEO (or person of like responsibility) must be reported, along with the next four most compensated officers and/or employees. In addition, if the next five most highly compensated officers and/or employees earn more than \$100,000 report those

additional five for a maximum of ten reported officers/employees. The form requires amounts for the current year and the last two years for each officer/employee. See the NAIC Health Annual Statement Instructions for further guidance.

The Notes to the Financial Statements are an essential part of the Annual Statement. When addressing the notes, show a “none” or “not applicable” if appropriate. Do not alter the numbering of the notes. These disclosures are to be consistent with those required by the standards set by the AICPA. The NAIC Health Annual Statement Instructions contain complete instructions and examples for each note.

All items listed as “other” with a value of 10% or greater of total assets, total liabilities, total revenue, total expenses, etc. must be broken out as a “Detailed Write In” with an appropriate identification including:

- (a) Aggregate write-ins for gains or (losses) in surplus, in Statement of Revenue and Expenses, Page 5, Line 47 and,
- (b) Other cash provided (applied), in Cash Flow, Line 16.6.

Disclose these items in the MD&A and in the Notes to Financial Statement when applicable.

If your DPO is not a separate legal entity in New Jersey, please provide a second “Underwriting and Investment Exhibit Part 1 Premiums” which reflects your New Jersey business only.

Every DPO shall submit no later than March 1, the New Jersey specific annual supplements (attached) in its entirety. Mark “N/A” or “None” if a schedule is non-applicable. For the Projection Requirements, if your DPO is a multi-state, entity please provide a second exhibit “2” which reflects your New Jersey business only.

Every DPO shall submit quarterly reports no later than 45 days following the close of each calendar quarter (that is May 15, August 15, and November 15 respectively), completed in accordance with SAP using the most current format for the quarterly NAIC blank. Specific quarterly instructions will be posted on the Department’s website.

**RISK-BASED CAPITAL (RBC) REPORT:** Every DPO is required to file the RBC Report unless they meet the following exceptions:

- 1. Is a domestic health organization that:
  - i. Writes direct business only in this State;
  - ii. Assumes no reinsurance in excess of five percent of direct premium written; and
  - iii. Writes direct annual premiums for comprehensive medical business of \$2 million or less;

or

- 2. Is a limited health service organization that covers less than 2,000 lives.

**Holding Company Act. Requirements - Annual Form B/C/F:** Every DPO is required to file the Holding Company Requirements unless the DPO meets the exceptions listed above.

MAILING ADDRESS

Every DPO shall submit the below required amount of copies of the following reports to:

Kwame Asare  
Supervising Insurance Examiner  
NJ Department of Banking and Insurance  
Office of Solvency Regulation  
PO Box 325 (if sent by United States Postal Services)  
Trenton, NJ 08625-0325

20 West State Street, (if sent by FedEx or UPS)  
Trenton, NJ 08608-1206

Item	Copies
Annual Statement	3
Annual Supplement	3
Audited Annual Financial Statements	2
Quarterly Reports	3

The Commissioner of Banking and Insurance has the regulatory authority (N.J.A.C. 11:10-1.13(b)) to impose enforcement remedies against any DPO that fails to reply to any inquiry of the Commissioner or fails to file quarterly or annual reports pursuant to this subchapter and shall be subject to penalties pursuant to N.J.S.A. 17B:21-2.

If you have any questions concerning this correspondence, please contact Tim Stroud at (609) 940-7452 or e-mail at [Tim.Stroud@dobi.nj.gov](mailto:Tim.Stroud@dobi.nj.gov).

# State of New Jersey



## Department of Banking and Insurance

### Dental Plan Organization (DPO) Supplement to the Annual Report of

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**(Name of DPO)**

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**Address**

For the Year Ended  
December 31, 20\_\_\_\_

Submitted By:

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(Printed Name & Title of Responsible Financial Officer Completing Report)

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(Original Signature of Officer )

(Date)

---

(Telephone Number)

(Fax Number)

(Email Address)

**State of New Jersey  
Department of Banking and Insurance  
DPO Annual Supplement**

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**GENERAL INFORMATION AND INSTRUCTIONS**  
**For Filing Dental Plan Organization (DPO) Supplement to the Annual Report**

**GENERAL**

1. Date of Filing: The report is required to be filed on or before March 1<sup>st</sup> for the preceding calendar year, unless March 1<sup>st</sup> falls on the weekend than it is to be filed on the 1<sup>st</sup> business day before March 1<sup>st</sup>.
2. The reporting date and the name of the company must be plainly written or stamped at the top of all pages and exhibits (and duplicate exhibits) and also upon all inserted exhibits and loose sheets.
3. Printed statements or copies produced by some duplicating process, in lieu of handwritten or typewritten statements on the actual blanks furnished on our website ([www.state.nj.us/dobi/managed.htm](http://www.state.nj.us/dobi/managed.htm)) by this Department will be accepted if such statements and supporting exhibits contain all the required information, with the same headings and footnotes, and are of the same size (8 ½" X 11") and arrangement, page for page, column for column, and line for line, as in the blanks available on this Department's website, unless the company is otherwise instructed.
4. Unanswered questions and blank lines or exhibits are not acceptable. If no answers or entries are to be made, write "None", not applicable (N/A), or "-0-" in the space provided.
5. Any item which cannot be readily classified under one of the printed items should be entered on a blank line and adequately described.
6. If additional supporting statements or exhibits are added in connection with answering interrogatories or providing other information, the additions should be properly keyed to the item being answered. (Example – "Interrogatories, #7).
7. The cover page must be manually signed by the appropriate corporate officer.
8. If this report does not contain the required information in the blanks or is not prepared in accordance with these instructions, it will not be accepted and late fees may be assessed.
9. This Annual Supplement relates to the Dental Plan Organization (DPO) only and private practice dentistry or other non-dental plan activities should not be included herein.

## **GENERAL INTERROGATORIES**

Information requested in many questions is required by Statute and serves to update our records in various areas. Remember to key in any information as instructed above where an attachment is required to answer a question.

### **INSTRUCTIONS FOR SUPPORTING EXHIBITS**

Exhibit 3A & 3B: Include written and oral complaints. Oral complaints should be recorded for file. Reason/Cause should be categorized in broad terms.

Exhibit 4: Each individual malpractice claim should be reported in this exhibit.

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_\_

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**GENERAL INTERROGATORIES**

1. Is the DPO directly or indirectly owned or controlled by any other company, corporation, or group of companies, partnership or individual?

ANSWER: \_\_\_\_\_ If "Yes", provide particulars:

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2. Are all dentists currently employed by or under contract with the DPO licensed to practice dentistry in their state of residence?

ANSWER: \_\_\_\_\_ If "No", provide particulars:

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3. Has any change been made since the last reporting date in the:

A. charter, articles of incorporation, or bylaws?

ANSWER: \_\_\_\_\_ If "Yes", attach current copies of the documents if they have not been previously submitted to the Department.

B. contracts with dentists or group or individual contract holders?

ANSWER: \_\_\_\_\_ If "Yes", submit these forms to the Health Insurance Bureau on proper filing format for review, if not already submitted.

C. Current schedules of premiums.

ANSWER: \_\_\_\_\_ If "Yes", submit current schedules to the Office of Life and Health Actuaries if not previously submitted.

**Name of DPO**

\_\_\_\_\_

**For the Calendar Year Ended December 31, 20\_\_**

\_\_\_\_\_

4. Has any present or former officer, director or any other person or firm had any claim of any nature whatsoever against the DPO which is not included in the statement of liabilities?

ANSWER: \_\_\_\_\_ If "Yes", provide details:  
\_\_\_\_\_  
\_\_\_\_\_

5. Are officers and employees of the DPO covered by a fidelity bond?

ANSWER: \_\_\_\_\_ Provide a copy of the certificate of coverage:

6. Have damage claims for medical or dental injury been initiated against the DPO during the reporting year?

ANSWER: \_\_\_\_\_

7. Have any other legal actions been taken against the DPO during the reporting year?

ANSWER: \_\_\_\_\_ If "Yes", attach additional sheets providing full particulars.

8. Provide the following information on your general liability and malpractice insurance coverage, if any:

	General Liability		Malpractice	
Name of Carrier				
Limits of Coverage				
Deductible				
Coinsurance				
Maximum Benefit				
Expiration Date				

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

**EXHIBIT 1**

**Restricted Deposit**

Deposit Required Per NJAC 11:10-1.8(a)	Market Value of Deposit at 12/31/20____
\$50,000	\$ _____

**General Surplus**

General Surplus <u>required</u> per NJAC 11:10-1.8(a)3, (the greater of \$100,000 or 1% of the current annual premium at 12/31/____). \$ _____
General Surplus at year ended 12/31/____ \$ _____

**Special Contingent Surplus (if applicable)**

Special Contingent Surplus per NJS 17:48D-7
Full Time Equivalent Dentists (FTE) = _____
Contingent Surplus year ended 12/31/20__ \$ _____

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

**EXHIBIT 2**

**20\_\_ Budget**  
(All costs in 000's)

	<b>1<sup>ST</sup> QTR Projection</b>	<b>2<sup>nd</sup> QTR Projection</b>	<b>3<sup>rd</sup> QTR Projection</b>	<b>4<sup>th</sup> QTR Projection</b>
Premium				
Other Income				
Total Revenue				
Primary Capitation				
Specialist Pool Exp.				
Total Medical Exp.				
Medical Loss Ratio				
Total Admin. Exp.				
Admin. Exp. Ratio				
Income/Loss				
Taxes				
Net Income/Loss				
Membership#				
Member Months##				
General Surplus				
Gen. Surp. Req.				
Restricted Deposits				
FTE Dentists (Prim)				
FTE Dent. (Special)				

# At end of Quarter (Include both Employees and Dependents)  
## Summary of members for all three months in the quarter . Member months exposed equals the sum of the number of months that each enrollee was covered during the quarter (e.g., if 100 enrollees were covered for 3 months and 50 enrollees were covered for 2 months, the total member months exposed would be 400 (100X3+50X2)).

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

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**EXHIBIT 3A**      **Complaint Data (Internal Only)**

A. Outstanding Complaints

Name	Group	Date	Reason

B. Summary by Number

- 1. Complaints outstanding prior reporting year \_\_\_\_\_
- 2. Complaints made current reporting year \_\_\_\_\_
- 3. Complaints resolved current reporting year \_\_\_\_\_
- 4. Complaints outstanding current reporting year \_\_\_\_\_

C. Summary by Cause (top four reasons) of Complaints made during the year.      Number

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Please furnish a description of the member complaint procedure.

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

**EXHIBIT 3B**      **Complaint Data (External Only)**

A. Outstanding Complaints

Name	Group	Date	Reason

B. Summary by Number

1. Complaints outstanding prior reporting year \_\_\_\_\_
2. Complaints made current reporting year \_\_\_\_\_
3. Complaints resolved current reporting year \_\_\_\_\_
4. Complaints outstanding current reporting year \_\_\_\_\_

C. Summary by Cause (top four reasons) of Complaints made during the year.      Number

1. \_\_\_\_\_
3. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Please furnish a description of the member complaint procedure.

**EXHIBIT 4**

**Malpractice Claims (those made during the year or still outstanding)**

Dentist	Date Made	Amount	Disposition	Date Disposed

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

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**EXHIBIT 5**

In reverse chronological order, specify the number of “full-time equivalent dentists” (FTE) as defined at NJAC 11:10-1.3 under contract with the DPO at the end of the year specified. Start at the current reported year, then go back two years (the current year end should be first)

<b>YEAR ENDED</b>	<b>FTE</b>
<b>20____</b>	
<b>20____</b>	
<b>20____</b>	

**EXHIBIT 6** On a separate sheet, list and describe any management and service contracts and all cost sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles, involving the organization or any affiliated organization.

**EXHIBIT 7**

**Enrollment Data**

List the number of group and non-group contracts in force and the group and non-group enrollees at:

[Start at the current reported year, then go back one year (the current year end should be first)]

<b>Date</b>	<b>Group Contracts</b>	<b>Group Employees</b>	<b>Group Dependents</b>	<b>TOTAL Enrollees</b>
<b>12/31/____</b>				
<b>12/31/____</b>				

<b>Date</b>	<b>Non-Group Contracts</b>	<b>Non-Group Subscribers</b>	<b>Non-Group Dependents</b>	<b>TOTAL Enrollees</b>
<b>12/31/____</b>				
<b>12/31/____</b>				

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

**Exhibit 8**

1. Do you have a Specialist Pool?

Answer: \_\_\_\_\_

If yes, estimate payments incurred in 20\_\_\_\_.

\$ \_\_\_\_\_

2. Do you have methods of compensation other than periodic capitation or specialist pool?

Answer: \_\_\_\_\_

If yes, briefly describe this other method of compensation.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, what are the total payments made in 20\_\_\_\_ using this other method of compensation?

\$ \_\_\_\_\_

Name of DPO \_\_\_\_\_

For the Calendar Year Ended December 31, 20\_\_\_\_

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**Exhibit 9**

**Benefit Plans**

**List in reverse chronological order how many types of benefit plans are being offered. Start at the current reported year, then go back two years (the current year end should be first)**

Year ended

Benefit Plans

12/31/\_\_\_\_

\_\_\_\_\_

12/31/\_\_\_\_

\_\_\_\_\_

12/31/\_\_\_\_

\_\_\_\_\_



**ATTACHMENT FOR MUTI-STATE DPOs**

New Jersey Only Business

DPO \_\_\_\_\_ Statement as of Year Ending 20\_\_\_\_

(All costs in '000's)

	<b>1<sup>st</sup> Qtr. Actual</b>	<b>2<sup>nd</sup> Qtr. Actual</b>	<b>3<sup>rd</sup> Qtr. Actual</b>	<b>4<sup>th</sup> Qtr. Actual</b>
Premium	_____	_____	_____	_____
Other Income	_____	_____	_____	_____
Total Revenue	_____	_____	_____	_____
Primary Capitation	_____	_____	_____	_____
Specialty Pool Exp.	_____	_____	_____	_____
Total Medical Exp.	_____	_____	_____	_____
Medical Loss Ratio	_____	_____	_____	_____
Total Admin. Exp.	_____	_____	_____	_____
Admin. Exp. Ratio	_____	_____	_____	_____
Income/Loss	_____	_____	_____	_____
Taxes	_____	_____	_____	_____
Net Income/Loss	_____	_____	_____	_____
Membership#	_____	_____	_____	_____
Member Months##	_____	_____	_____	_____
General Surplus	_____	_____	_____	_____
Gen. Surp. Req.	_____	_____	_____	_____
Restricted Deposits	_____	_____	_____	_____
FTE Dentists (Prim)	_____	_____	_____	_____
FTE Dent. (Special)	_____	_____	_____	_____
Contingent Surp.	_____	_____	_____	_____

# At the end of each Quarter (**Include both Employees and Dependents**)  
 ## Summary of members for all three months in the quarter. Member months exposed equals the sum of the number of months that each enrollee was covered during the quarter (e.g., if 100 enrollees were covered for 3 months and 50 enrollees were covered for 2 months, the total member months exposed would be 400 (100X3+50X2)).