

Notice of Intent to Apply Form for Medicare Advantage (MA) Medical Savings Account (MSA) Plan Demonstration in 2008

Complete this form to indicate your intent to apply for an MSA plan under the demonstration program if you are a new applicant to CMS or if you are under an existing contract, but intend to apply for an additional contract.

Applicant Organization's Legal Entity Name:

Applicant Organization's Corporate Address (*Street, City, State, Zip – No Post Office Boxes*):

Complete this section for ALL requests for NOI. PROVIDE THE INFORMATION BELOW FOR THE PERSON WHO WILL ACT AS THE MAIN CONTACT	
Name of Individual:	Title:
Address of Individual: (<i>Street, City, State, Zip – No Post Office Boxes</i>):	
Direct Telephone Number:	Fax Number:
Email Address:	
PROVIDE THE INFORMATION BELOW FOR THE PERSON WHO WILL ACT AS A BACKUP FOR THE MAIN CONTACT	
Name of Individual:	Title:
Address of Individual: (<i>Street, City, State, Zip – No Post Office Boxes</i>):	
Direct Telephone Number:	Fax Number:
Email Address:	
Please indicate your intent to offer an MSA product in the individual market and/or the employer group market.	
<input type="checkbox"/> Individual market <input type="checkbox"/> Employer group market <input type="checkbox"/> Both	
If you intend to offer a product in the individual market, please identify the proposed service area:	
If you intend to offer a product in the employer group market, please identify the proposed service area:	