



**STATE OF CONNECTICUT**  
**INSURANCE DEPARTMENT**

**Network Adequacy**  
**Certificate of Compliance**  
*(To be signed by an officer of the company)*

I, \_\_\_\_\_,  
*(Printed Name)* \_\_\_\_\_  
*(Title)*

hereby certify that the network(s) of providers utilized by \_\_\_\_\_  
*(Health Carrier)*

is/are consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards, in accordance with C.G.S Section 38a-472f.

\_\_\_\_\_  
*(Signature)*

\_\_\_\_\_  
*(Date)*

Subscribed and sworn to before me on this \_\_\_\_\_ day of \_\_\_\_\_, 2016.

\_\_\_\_\_  
Commissioner of Superior Court or Notary

\_\_\_\_\_  
Commission Expiration Date