



**State of Illinois**  
**ACA QHP Certification of Compliance**

The undersigned represents and warrants that he/she is a duly authorized officer of the Company named below, and hereby certifies that he/she is knowledgeable concerning the requirements necessary to comply with federal ACA and associated health care reform legislation, and that the policy forms contained herein and the associated documents and any other reporting requirements conform with all state and federal laws and regulations.

I understand that the Illinois Department of Insurance will rely on this Certification of Compliance for the QHP Application Checklist, policy forms contained herein, along with associated documents. Should it subsequently be determined that these documents listed do not comply with the required statutes and regulations or that this certification is false or incorrect, corrective and disciplinary action, including retroactive disapproval, as authorized by law, may be taken by the Department against the Company.

The Company must complete and file with the Department in its SERFF binder the Statement of Detailed Attestation Responses required for State Partnership QHP Issuers. The attestation form can be found at: [State Partnership Exchange Issuer Attestations](#).

By: _____	Date: _____
Printed name: _____	
Title: _____	
Company: _____	Company FEIN: _____
Address: _____	Company NAIC #: _____
City, State, Zip: _____	
Phone: _____	
Email: _____	