GROUP DISCLOSURE FORM

Disclosure statement should be completed no more than 30 days prior to the Effective Date.

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DISCLOSURE STATEMENT

Participant(s) shall include all Active employees, COBRA beneficiaries and their dependents, Retirees *(if applicable)* and Disabled persons. Disclosed individuals, who are required to be disclosed are **(a)** All employees and dependents who are medically confined; **(b)** All high dollar claimants; and **(c)** All claimants with possible catastrophic medical conditions, including, but not limited to, those persons currently eligible under the plan that were formerly ineligible due to meeting their lifetime maximum in the past.

Full Legal Name of Plan Sponsor _____

APPLICANTS

Please list any Participant(s) who have paid or pending claims in excess of 50% of the specific deductible, or excess of $10,000 in paid claims, during the past 12 months or could reasonably be expected to have claims in excess of this amount. This should include any Participant(s) known to have cancer *(specific type: ex. leukemia)*, HIV/AIDS, severe cardiovascular disease, any severe disorder of a major organ system, severe burns or trauma, neonatal disorders, brain or spinal injuries, or potential organ *(specific type)* transplant. If the diagnosis or course of treatment of disclosed individuals changes prior to the effective date, we reserve the right to re-evaluate the risk and place a separate individual specific deductible on that individual, if necessary.

Name	Date of Birth	Date of Disability	Diagnosis/Prognosis	Current Treatment	Amounts Paid Pending	Currently Confined

DISABLED INDIVIDUALS AND RETIREES *(Please indicate "None" if there are not any)*

Disabled Individuals are those employees not actively at work (*or, in the case of a dependent or Continuation Beneficiary, is by disability unable to perform his or her normal functions of a person of like sex and age)* on the Effective Date of this Contract or the date such person becomes eligible for coverage under the Employee Benefit Plan.

Name	Date of Birth	Date of Disability	Diagnosis/Prognosis	Current Treatment	Amounts Paid Pending	Currently Confined

COBRA MEMBERS *(Please indicate "None" if there are not any)*

Name	COBRA Effective Date	Reason

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Underwriting Management Expert's quote is based upon the request for proposal submitted, including, but not limited to the claims experience. Any errors or omissions in the data and experience submitted may necessitate either revision or rescission of the quote(s). Coverage will not be bound until Underwriting Management Expert's underwriting department has reviewed all requested information and all disclosure information. Coverage will be bound upon review and acceptance of this information by Underwriting Management Experts.

The Plan Sponsor, through its authorized representatives, warrants and represents that the above list and additional pages attached, is true, complete and accurate to the best of his/her knowledge and belief, and that nothing has been knowingly or intentionally omitted.

I have reviewed this completed form and the information given is complete and accurate, to the best of my knowledge. I understand that if the information given is not complete and accurate, the excess loss coverage proposed may be re-evaluated and Participants not disclosed may be individually underwritten retroactively to the effective date. The Insurer(s) reserves the right to terminate or limit the Participant's participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific and Aggregate Stop Loss coverage quoted. The Plan Sponsor further acknowledges, understands and agrees that the information provided herein may be used by the Insurer(s) in evaluating and determining the acceptability of the Plan Sponsor's risk and that no coverage shall be provided for such person(s) unless specifically agreed in writing by the Insurer(s).

THIS INFORMATION SHALL BE TREATED CONFIDENTIALLY

Plan Sponsor _____

Officers Signature _____

Name/ Title _____

Date _____

Third Party Administrator _____

Signature _____

Name/ Title _____

Date _____