Stop Loss Disclosure Form and Instructions for Completing

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of "health care operations". Life and Health Insurance Company and the MGU shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

The Company and MGU will rely upon the information provided on the attached disclosure form, which will become part of the application for stop loss coverage. The purpose of the form is to allow the Company to take underwriting action on all known individuals in the categories listed below. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known, or which should have been known, as of the date of this disclosure by making a though review of all applicable records in their possession or in the possession of a service provider such as a Third Party Administrator. Such records shall include, but not be limited to, historical claim reports, disability records, payroll records and current information from administrators, insurers, utilization management companies, managed care companies, pharmacy benefit management companies and any Agent/Broker of the Plan Sponsor.

In exchange the Company will accept the liability for any truly unknown claimants. **The attached disclosure form must be completed and signed by the appropriate parties no earlier than thirty (30) days prior to the proposed Effective Date of stop loss coverage unless otherwise agreed to in writing** by the MGU and Life and Health Insurance Company and received by Life and Health Insurance Company within five (5) days of completion.

Upon receipt of the completed disclosure, Life and Health Insurance Company will assess all data, new and previously reported, and if the information provided is complete, will inform the producer in writing when accepted or of any necessary changes to the rates, factors or terms of coverage. If the information provided is incomplete, Life and Health Insurance Company reserves the right to request complete information before proceeding. We reserve the right to request individual medical Applications at any time. Life and Health Insurance Company reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

When completing the form, remember that Covered Persons include those on short or long-term disability, COBRA, FMLA, leave of absence, extension of benefits, sick time, vacation time or retirees covered under the plan and for whom coverage is requested in the quote. Please include anyone who recently lost coverage under the plan and is eligible for an extension of coverage under COBRA or a plan provision allowing for continued coverage under the plan even if that extension as not been elected.

It also includes anyone who previously reached a plan lifetime or annual maximum and is eligible for reinstatement under the plan under federal law.

Plan Sponsor ____________ **Date Signed** ____________ **Effective Date** ____________ **Initial** ______

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Stop Loss Disclosure Form

The following questions pertain to medical expenses of persons covered by the employee benefit plan ("Plan"). If the answer to any of the following questions is yes, provide complete details on page three of this form for each individual covered person and, if needed, attach supplemental reports (be sure to note the names and dates of supplemental reports provided with the disclosure statement). This information will be treated as confidential by Life and Health Insurance Company.

#	Question	Answer
1	Is this group currently covered under a fully insured policy? **If yes answer all questions**. *(If No, Skip to question 5)*	
2	Have all available claims and large claims data typically released by the Carrier in this state been provided?	
3	Have the renewal rates and headcounts been provided?	
4	How many employees are covered under the current plan?	
5	Are there any Covered Person(s) who are currently confined to a Medical facility, at home or elsewhere, in Case Management, in Disease Management or have been pre-certified within the last three months?	
6	Have any Covered Person(s) received medical services during the current plan year the cost of which exceeds the lesser of 50% of the lowest Specific Retention Amount applied for or $50,000?	
7	Have any Covered Person(s) been identified as a candidate(s) for Case Management and/or as having the potential to exceed during the policy period, the lesser of, 50% of the lowest Specific retention amount applied for or $50,000?	
8	During the current plan year, has any Covered Person(s) been diagnosed with or treated for a condition represented by any of the ICD-9 and ICD-10 codes contained in the attached list?	
9	Has any Covered Person(s) been evaluated for, accepted into or listed at a transplant program?	
10	Has any current or former Covered Person(s) previously met the plan's maximum in the current or prior years?	
11	If the answer to 10 is yes, have you offered reinstatement into the plan?	
12	Has any Covered Person(s) accumulated more than $500,000 of claims while covered under the plan?	
13	Are there any Covered Person(s) currently, or in the last 180 days, on Workman's Compensation, Disability, COBRA, In COBRA Election period, FMLA, Medical leave, Retiree or Hospitalized? **If Yes, PLEASE COMPLETE EMPLOYEE DETAIL ON PAGE 3. Details must be provided on these employees, and their dependents, or an Individual Medical Questionnaire must be obtained.**	

If the Plan Sponsor fails to disclose any Plan Participant known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then the coverage proposed may be re-evaluated and any Covered Person(s) not disclosed may be individually underwritten retroactively to the effective date. We reserve the right to terminate or limit the covered Person's participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific or Aggregate coverage quoted.

Plan Sponsor ______ **Date Signed** ______ **Effective Date** ______ **Initial** ______

Revised 1/4/2019

Employer Stop Loss Disclosure Statement

Name	DOB	Sex	Emp Spouse Child	(A)ctive, (C)OBRA, (R)etiree or (T)ermed	Plan is (P)rime or (2)ary	Term Date/ COBRA Status Pending (Y/N)	Diagnosis	Most Recent Date of Service	Prog Cond Code (1-6)*	In CM (Y/N). If (Y), attach rpt(s)	Paid/ Pended Losses this Plan Year	Paid/ Pended Losses Since Coverage Began

* Condition Codes: Related to the condition listed the treatment plan for the next 12 months is anticipated to be: (1)None/Stable (2)Limited/Claims expected to decline(3)Ongoing/Expect similar claims (4)Extensive/Expect claims to increase (5)Hospice (6) None/Expired

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic claimants in accordance with the instructions attached to this form and that it is the result of a diligent search in accordance with those instructions. The Plan Sponsor recognizes that if the Plan Sponsor fails to disclose any Covered Person known to fall into one of the categories set forth in the instructions attached to this form, either intentionally or because a thorough review of all records was not conducted, then the coverage proposed may be re-evaluated and any Covered Person(s) not disclosed may be individually underwritten retroactively to the effective date. We reserve the right to terminate or limit the covered Person's participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific or Aggregate coverage quoted. If supplemental reports are being provided to meet the disclosure criteria, please check the box below and list the name and date of the reports provided:

☐ ____________________

	Plan Sponsor	Claims Administrator	Broker/Agent
Company Name			
Signature			
Name			
Title			
Date			

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Indications of Potentially Complex Medical Conditions by ICD9 and ICD10

DISCLOSURE REFERENCE TOOL

The following list suggests conditions and related ICD9(s) and ICD10(s) which may indicate potentially complex medical conditions. Its purpose is to provide a tool to help our clients identify cases which should be considered for disclosure purposes. It is not intended to be used as an all inclusive disclosure listing. Please refer to the disclosure statement terms for specific requirements to assure complete disclosure.

Condition	ICD9(s)	ICD10(s)
AIDS		
Human Immunodeficiency Virus	042	B20
Kaposi's Sarcoma	176	C46x
Pneumocystis Carinii Pneumonia	136.3	B59
Primary Coccidioidomycosis (pulm)	114.0	B38.0
Toxoplasmosis	130x	B58x
Cardiac and Pulmonary Disease/Disorders		
Aortic Aneurysm	441x	I71x
Cardiac Arrest	427.5	I46.9
Cardiomyopathy	425x	I42x
Cardiac Complications	997.1	I97.10, I97.790, I97.88-.89
Cerebrovascular Disease-Acute	436	I67.89
Cerebrovascular Disease	430-432, 434.1	I60.9, I61.9, I62x, I66x, I63.40
Chronic Airway Obstruction	496	J44.9
Cystic Fibrosis	277.0-277.09	E84x
Heart Failure	428x	E50x
Ischemic Heart Disease	410-411.1	I50x
Post Infammatory Pulm. Fibrosis	515	I21x, I24.1, I20.0
Primary Pulmonary Hypertension	416.0	I27.0
Respiratory Arrest/Failure	799.1, 518.81	R09.2, J96x
Disease of Blood		
Agranulocytosis	288.0	D70x
Aplastic Anemia (Unspecified)	284, 284.8 -.99	D60x, D61.9
Aplastic Anemia (Constitutional)	284.0	D61x
Coagulation Defects	286x	D66.0-68.99
Myelodysplastic Syndrome	238.7	D47x
Thalassemia	282.4	D56x
Sickle Cell Anemia	282.6	D57x
High Risk Pregnancy, Neonate, Pediatric		
Birth Trauma	767x	P10-P15.99, P52x
Bronchopulmonary Dysplasia	770.7	P27x
Cardiac Complications	668.1	074.2-O89.1
Fetal Anomaly affecting Maternal Mgt.	655x	O350XX0-O35.9XX0
Congenital Anomaly	740x-759x	Q00.0-Q89.99
Disorders related to Low Birth Weight	765.0-765.1	P07.01-P07.30
Disorders related to Short Gestation	765.20-765.27	P07.20-P07.37
Intrauterine Hypoxia & Birth Asphyxia	768x	P84
Multiple Gestation	651x	O03.009-O30.93
Premature Rupture of Membranes	658.13	O42.011-O42.013
Respiratory Distress Syndrome	769	P22.0
Respiratory Syncytial Virus (RSV)	079.6	B97.4
Supervision of High Risk Pregnancy	V23	O09.00-O09.93
Chronic Psychiatric Disorders		
Schizophrenia	295-295.99	F20.89-F20.99
Mood Disorders	296-296.99	F30.10-F34.8
Alcohol Dependence	303-303.99	F10.229-F10.21
Drug Dependence	304-304.99	F11.20-F19.21
Anorexia Nervosa	307.1	F50.00

Condition	ICD9(s)	ICD10(s)
Neuromuscular Disorders		
Cerebral Palsy	343x	G80.0-G80.99
Lou Gehrig's Disease (ALS)	335.20	G12.21
Guillian-Barre Syndrome	357.0	G61.0
Multiple Sclerosis	340	G35
Muscular Dystrophies & Other Myopathies	359x	G71.2-G72.9
Cancer (Malignant Neoplasm)	140x-199x	C00.0-C80.2
Malignant Neoplasm of Lymphatic & Hemopoietic Tissue		
Leukemia: Monocytic: Other Unsp Cell Type	206x-208x	C93.00-C95.92
Hodgkin's Disease	201x	C81.70-C81.98
Lymphoid Leukemia	204x	C91.00-C91.92
Lymphosarcoma and Other	200x, 202x	C83.30-C96.Z
Multiple Myeloma	203x	C90.00-C90.32
Myeloid Leukemia	205x	C92.00-C92.92
Miscellaneous Conditions		
Alpha-1-Antitrypsin Deficiency	273.4	E88.01
Amyloidosis	277.3	E85.1-E85.99
Crohn's Disease	555x	K50x
Diabetes Mellitus Complications	250.7, 785.9	E10.65-E11.51, R09.89
Hepatitis	070x	B15.0-B19.9
Immune Deficiencies	279x	D80.1-D89.9
Lipidoses (Gaucher's and Fabry Disease)	272.7	E75.21-E77.1
Morbid Obesity	278.0	E66x
w/BMI > 25	V85.2-V85.4	Z68.25-Z68.45
Neurofibromatosis	237.70 - .72	Q85.00-Q85.02
Pancreatitis - Chronic	577.1	K86.1
Systemic Lupus Erythematosus	710.0	M32.10
Tuberculosis	010x-018x	A15.7-A19.9
Joint Disorders	719-719.99	M25.40-M25.99
Spinal Disorders	720-724.99	M43.8x9, M53.9
Multiple Trauma		
Burns (over 20% of total body surface)	948.2-949	T30.0-T31.20
Closed Head Injury	803x	S02.91XA-S06.9X0A
Coma	780.01	R40.20
Complications of Trauma	958-958.8	T79.0XXA-T79.8XXA
Multiple Trauma	958.8	T07
Spinal Cord Injury	952, 344x, 806x	S12.000A, S14.109A-S34.139A, G82.50-83.99
Transplantation, Failure & Complications		
Transplantation	V42-V58.9	Z94x, Z51.89
Complication of Transplanted Organs/Organ Rejection	996.8-996.89	T86.890-T86.90
Renal Failure	584 - 586	N17.0-N19
Liver Failure	572.8	K72.10-K72.90

Note: "x" denotes the entire range of subset numbers (.0-.99)

This listing suggests conditions and related ICD9(s) and ICD10(s) which may indicate potentially complex medical conditions. Its purpose is to provide a tool to help our clients identify cases which should be considered for disclosure purposes. It is not intended to be used as an all inclusive disclosure listing. Please refer to the disclosure statement terms for specific requirements to assure complete disclosure.

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