STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
Three Town Park Commons, 225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144 (800-447-0460)

APPLICATION

***** STATE VARIATIONS MAY APPLY *****

1. Full Legal Name of Applicant and Address:

Telephone No.:

2. Applicant is a/an (check one)**:**
☐ Single Employer Plan ☐ Student Plan
☐ Union or Taft Hartley Plan
☐ Association Plan or MEWA
☐ Other:

3. Policy Period: Effective Date: Expiration Date:

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries:
☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:

6. Contact Person at Applicant:

7. Enter full name of the Medical Benefit Plan(s):
A signed copy of such Medical Benefit Plan(s) will form part of this contract.

8. Name and Address of Claims Administrator:

9. Agent of Record:

10. Estimated Initial Enrollment: Single: Family: Total Covered Units:

11. Retirees Covered: ☐ Yes ☐ No

12. The Utilization Review vendor will be:

13. Deposit Premium (Minimum of first month's estimated premium)**:** $XXXX
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. SPECIFIC STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Medical Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Policy Period per Covered [Person][Family]: $XXXX

C. Contract Basis: XX/XX
Covered Expenses Incurred from [Date] through [Date] and Paid from [Date] through [Date]

If a claim is eligible under two different Contract Bases, it may only be filed for reimbursement in the earliest Contract Basis under which it is eligible.

D. Specific Policy Period Reimbursement Maximum per Covered [Person][Family]: $XXXX

E. Monthly Specific Premium Rates: $XXXX

F. Specific Percentage Reimbursable: XXX%

G. Specific Terminal Liability Option: ☐ Yes ☐ No
Specific Terminal Liability Option premium per Covered Person per month: $XXXX

15. AGGREGATE STOP LOSS INSURANCE: ☐ Yes ☐ No

A. Covered Expenses Paid under the Medical Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card
☐ Prescription Drugs Under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $XXXX
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis: XX/XX
Covered Expenses Incurred from [Date] through [Date] and Paid from [Date] through [Date]

If a claim is eligible under two different Contract Bases, it may only be filed for reimbursement in the earliest Contract Basis under which it is eligible.

D. Aggregate Policy Period Reimbursement Maximum: $XXXX

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Composite						
Single						
Family						

F. Aggregate Percentage Reimbursable: XXX%

G. Loss Limit: $XXXX
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered [Person][Family], which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Policy Period: $XXXX
2. ☐ Monthly Premium rate per Covered Unit: $XXXX
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month: $XXXX
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month: $XXXX

SPECIAL LIMITATIONS:

Specific:

_____

_____

Aggregate:

_____

_____

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Claims Administrator retained by the Applicant will be considered the Applicant's agent, and not the Company's agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, is subject to review by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Medical Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Medical Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Medical Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

FRAUD STATEMENT:
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Full Legal Name of Applicant: _____

Dated at _____ this _____ day of _____, 20_____

_____ _____
Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Use Only: ACCEPTANCE
Accepted on behalf of the Company, this ____ day of _____, 20____

By:_____ Title: _____

Policy No.: _____