

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

APPLICATION

1. Full Legal Name of Applicant and Address: Sample Group, Inc. 123 State Street AnyTown, USA 07041-776 Telephone No.:	2. Applicant Sponsors a/an (check one): ☒ Single Employer Plan ☐ Student Plan ☐ Union or Taft Hartley Plan ☐ Association Plan or MEWA
3. Policy Period: Effective Date: 10/01/2026 Expiration Date: 09/30/2027	
4. If affiliates, subsidiaries and/or other major locations are to be included in coverage, a list that includes each entity's full legal name and address is attached.	
5. Nature of Business of the Applicant to be Insured: Amusement & Recreation Services, NEC	6. Contact Person at Applicant:
7. Enter full name of the Medical Benefit Plan(s): Sample Group, Inc. Benefit Plan	
8. Name and Address of Claims Administrator: Meritain Health 502 Sunport Lane Orlando, FL 32809	
9. Agent of Record: John Snellings Insurance Agency, LLC.	
10. Estimated Initial Enrollment: Single: 317 Employee + Spouse: 13 Employee + Child(ren): 29 Family: 15 Total Covered Units: 374	
11. Retirees Covered: ☐ Yes ☒ No	
12. The Utilization Review vendor will be: American Health Holding, Inc. - UR	
13. Deposit Premium (Minimum of first month's estimated premium): \$ 52,722.10 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: \$150,000 C. Contract Basis: 12/18 + Gap Covered Expenses Incurred from 10/01/2026 through 09/30/2027, and Paid from 10/01/2026 through 03/31/2028 or expenses Incurred from 02/01/2022 through 09/30/2026, and Paid from 04/01/2027 through 03/31/2028. 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: Unlimited E. Monthly Specific Premium Rates: Single: \$108.20 Employee + Spouse: \$215.55 Employee + Child(ren): \$190.76 Family: \$323.75 F. Specific Percentage Reimbursable: 100% G. Specific Terminal Liability Option: ☐ Yes ☒ No Specific Terminal Liability Option premium per Covered Person per month:	

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: \$3,406,807.20
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis: 24/12
Covered Expenses Incurred from 10/01/2025 through 09/30/2027, and Paid from 10/01/2026 through 09/30/2027.

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: \$1,000,000

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Single	\$646.84					
Employee + Spouse	\$1,288.52					
Employee + Child(ren)	\$1,140.39					
Family	\$1,935.35					

F. Aggregate Percentage Reimbursable: 100%

G. Loss Limit: \$150,000
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, 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:

- ☐ Annual Premium payable in advance for Policy Period:
- ☒ Monthly Premium rate per Covered Unit: Composite: \$12.99
- ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month:
- ☒ Aggregate Terminal Liability Option premium per Covered Unit per month: \$1.00

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: Sample Group, Inc.

Dated at _____ this _____ day of _____, 20____

Officer / Partner Signature (print name)

Licensed Agent Signature (print name)

For Lasso Healthcare Insurance Company Use Only: ACCEPTANCE

Accepted on behalf of the Company, this _____ day of _____, 20____

By: _____

Title: _____

Policy No.: _____

LASSO HEALTHCARE INSURANCE COMPANY
STOP LOSS INSURANCE

ADDENDUM TO THE APPLICATION

This Addendum is made a part of the Application (and Policy) to which it is attached. There are no changes to the Application (and Policy) under this Addendum, other than stated below. You and We agree to the following:

SPECIAL TERMS OR CONDITIONS

Full Legal Name of Applicant: Sample Group, Inc.

Dated at _____ this _____ day of _____, 20____

Officer / Partner Signature (print name)

Licensed Agent Signature (print name)