DISCLOSURE STATEMENT

GROUP NAME:

Participant(s) shall include active employees, COBRA beneficiaries, retirees and their dependents.

1. Please list any **Participant** who has paid or pending claims equal to or greater than $10,000 (for specific deductible levels up to $50,000) or equal to or greater than 50% of the specific deductible (for specific deductible levels in excess of $50,000) during the past 12 months or could reasonably be expected to have claims in excess of this amount in the next 12 months.

Participant	**Diagnosis**	**Amount Paid/Pended/Expected**	**Prognosis/Status**

2. Other than those **Participants** listed above, regardless of amount paid and/or pended, please list any **Participant** known to have multiple hospital admissions with the same diagnosis or any "serious condition", including but not limited to, Cardiovascular Conditions; Chronic Respiratory Conditions; AIDS and AIDS related Conditions; Neurological Conditions (including, but not limited to, ALS, Idiopathic Ployneuropathy, Giullian Barre, Multiple Sclerosis [MS], Cystic Fibrosis, Rey's Syndrome, Meningitis, or Encephalitis); Newborns with complications; Congenital Defects; Cerebral Vascular Accident; Renal Problems (Kidney); Hepatitis C; Cancer or history of Cancer; Accidents which may lead to the following: Amputations, Brain Injuries, Burns causing hospital confinement, Multiple Crushing or Fractures, Spinal Cord Injuries; or known to have or scheduled to have Organ Transplants, including Bone Marrow Transplants.

Participant	**Diagnosis**	**Amount Paid/Pended/Expected**	**Prognosis/Status**

3. Other than those **Participants** already listed above, please list any **Participant** who is disabled or hospital confined.

Participant	**Diagnosis**	**Date of Disability/Admission/Expected Discharge**	**Prognosis/Status**

4. Are expected benefits available from the prior insurer for presently disabled **Participants**? [ ] YES [ ] NO

5. Will any former **Participant** be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? [ ] YES [ ] NO

Please explain any "YES" answers to questions 4 and 5:

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After a thorough review of the records maintained by the Employer, the Employer's Claims Payor/TPA and the Employer's utilization review, pre-certification and large case management vendors, we represent that the above information is complete and accurate to the best of our knowledge and belief. We understand that if the information is not complete and accurate, the Excess Loss coverage proposed may be reevaluated, rerated, rescinded or declined and **Participants** not disclosed may be denied coverage or individually underwritten retroactively to the Effective Date.

Plan Sponsor/Employer: _____ Claims MGA/Administrator: _____

Officer's Signature: _____ Signature: _____

Name & Title: _____ Name & Title: _____

Date: _____ Date: _____