**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**: SIGNATURE/NAME **DATE SIGNED**: Click to enter date **EFFECTIVE DATE**: Click to enter a date. **INITIALS**: XX

**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.

|  |  |
| --- | --- |
| 1. Is this group currently covered under a fully insured policy? If yes answer all questions. (If No, Skip to question 5) | Choose an item. |
| 1. Have all available claims and large claims data typically released by the Carrier in the state been provided? | Choose an item. |
| 1. Have the renewal rates and headcounts been provided? | Choose an item. |
| 1. How many employees are covered under the current plan? | Enter text. |
| 1. 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? | Choose an item. |
| 1. 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? | Choose an item. |
| 1. 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? | Choose an item. |
| 1. During the current plan year, has any Covered Person(s) been diagnosed with or treated for a condition represented by any of the ICD-10 codes contained in the attached list? | Choose an item. |
| 1. Has any Covered Person(s) been evaluated for, accepted into or listed at a transplant program? | Choose an item. |
| 1. Has any Covered Person(s) accumulated more than $500,000 of claims while covered under the plan? | Choose an item. |
| 1. Are there any known dependents covered under the plan but not residing with the employee (former spouses, non-custodial parent, adult children) that are NOT included in the reporting? 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. | Choose an item. |
| 1. 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. | Choose an item. |

**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**: SIGNATURE/NAME **DATE SIGNED**: Click to enter date **EFFECTIVE DATE**: Click to enter a date. **INITIALS**: XX

**EMPLOYER STOP LOSS DISCLOSURE STATEMENT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DOB** | **Sex** | **E/SP/CH** | **(A)ctive, (C)obra, (R)etiree, (T)ermed** | **Plan is (P)rimary or (2)ary** | **Term date?**  **COBRA status pending? (Y/N)** | **Diagnosis** | **Most recent date of service** | **Prog Cond**  **Code (1-6)\*** | **In CM?\*\*** | **Paid/**  **pended losses this plan year** | **Paid/ Pended Losses Since Coverage Began** |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term date  Y/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |

\* 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.

\*\*if in CM, please attach reports.

\*\*\*If there are more claimants than available spaces, please provide on separate sheet

**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:**

If box is checked, please provide reports and list the name and date of the reports provided here

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PLAN SPONSOR (required)** | **CLAIMS ADMINISTRATOR\*** | **BROKER/AGENT (required)** |
| **COMPANY NAME** | PLAN SPONSOR NAME | TPA NAME | AGENCY NAME |
| **SIGNATURE** |  |  |  |
| **NAME** | SIGNERS NAME | SIGNERS NAME | SIGNERS NAME |
| **TITLE** | TITLE | TITLE | TITLE |
| **DATE** | DATE | DATE | DATE |

*\*If changing TPA’s, do not need to complete Claims Admin section*

**INDICATIONS OF POTENTIALLY COMPLEX MEDICAL CONDITIONSL BY ICD10**

**DISCLOSURE REFERENCE TOOL**

The following list suggests conditions and related 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.

|  |  |
| --- | --- |
| **AIDS** | **ICD10(s)** |
| Human Immunodeficiency Virus | B20 |
| Kaposi's Sarcoma | C46x |
| Pneumocystis Carinii Pneumonia | B59 |
| Primary Coccidioidomycosis (pulm) | B38.0 |
| Toxoplasmosis | B58x |
| **Cardiac and Pulmonary Disease/Disorders** | |
| Aortic Aneurysm | I71x |
| Cardiac Arrest | I46.9 |
| Cardiomyopathy | I42x |
| Cardiac Complications | I97.10, I97.790, I97.88-.89 |
| Cerebrovascular Disease-Acute | I67.89 |
| Cerebrovascular Disease | I60.9, I61.9, I62x, I66x, I63.40 |
| Chronic Airway Obstruction | J44.9 |
| COVID-19 | U07.1, U07.0 |
| Cystic Fibrosis | E84x |
| Heart Failure | E50x |
| Ischemic Heart Disease | I50x |
| Post Infammatory Pulm. Fibrosis | I21x, I24.1, I20.0 |
| Primary Pulmonary Hypertension | I27.0 |
| Respiratory Arrest/Failure | R09.2, J96x |
| Vaping-related Disorders | U07.0 |
| **Disease of Blood** | |
| Agranulocytosis | D70x |
| Aplastic Anemia (Unspecified) | D60x, D61.9 |
| Aplastic Anemia (Constitutional) | D61x |
| Coagulation Defects | D66.0-68.99 |
| Myelodysplastic Syndrome | D47x |
| Thalassemia | D56x |
| Sickle Cell Anemia | D57x |

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| **High Risk Pregnancy, Neonate, Pediatric** | **ICD10(s)** |
| Birth Trauma | P10-P15.99, P52x |
| Bronchopulmonary Dysplasia | P27x |
| Cardiac Complications | 074.2-O89.1 |
| Fetal Anomaly affecting Maternal Mgt. | O350XX0-O35.9XX0 |
| Congenital Anomaly | Q00.0-Q89.99 |
| Disorders related to Low Birth Weight | P07.01-P07.30 |
| Disorders related to Short Gestation | P07.20-P07.37 |
| Intrauterine Hypoxia & Birth Asphyxia | P84 |
| Multiple Gestation | O03.009-O30.93 |
| Premature Rupture of Membranes | O42.011-O42.013 |
| Respiratory Distress Syndrome | P22.0 |
| Respiratory Syncytial Virus (RSV) | B97.4 |
| Supervision of High Risk Pregnancy | O09.00-O09.93 |
| **Chronic Psychiatric Disorders** | |
| Schizophrenia | F20.89-F20.99 |
| Mood Disorders | F30.10-F34.8 |
| Alcohol Dependence | F10.229-F10.21 |
| Drug Dependence | F11.20-F19.21 |
| Anorexia Nervosa | F50.00 |
| **Neuromuscular Disorders** | |
| Cerebral Palsy | G80.0-G80.99 |
| Lou Gehrig's Disease (ALS) | G12.21 |
| Guillian-Barre Syndrome | G61.0 |
| Multiple Sclerosis | G35 |
| Muscular Dystrophies & Other Myopathies | G71.2-G72.9 |
| **Cancer (Malignant Neoplasm)** | C00.0-C80.2 |
| **Malignant Neoplasm of Lymphatic & Hemopoietic Tissue** | |
| Leukemia: Monocytic: Other Unsp Cell Type | C93.00-C95.92 |
| Hodgkin's Disease | C81.70-C81.98 |
| Lymphoid Leukemia | C91.00-C91.92 |
| Lymphosarcoma and Other | C83.30-C96.Z |
| Multiple Myeloma | C90.00-C90.32 |
| Myeloid Leukemia | C92.00-C92.92 |

|  |  |
| --- | --- |
| **Miscellaneous Conditions** | **ICD10(s)** |
| Alpha-1-Antitrypsin Deficiency | E88.01 |
| Amyloidosis | E85.1-E85.99 |
| Crohn's Disease | K50x |
| Diabetes Mellitus Complications | E10.65-E11.51, R09.89 |
| Hepatitis | B15.0-B19.9 |
| Immune Deficiencies | D80.1-D89.9 |
| Lipidoses (Gaucher's and Fabry Disease) | E75.21-E77.1 |
| Morbid Obesity | E66x |
| w/BMI > 25 | Z68.25-Z68.45 |
| Neurofibromatosis | Q85.00-Q85.02 |
| Pancreatitis - Chronic | K86.1 |
| Systemic Lupus Erythematosus | M32.10 |
| Tuberculosis | A15.7-A19.9 |
| Joint Disorders | M25.40-M25.99 |
| Spinal Disorders | M43.8x9, M53.9 |
| **Multiple Trauma** | |
| Burns (over 20% of total body surface) | T30.0-T31.20 |
| Closed Head Injury | S02.91XA-S06.9X0A |
| Coma | R40.20 |
| Complications of Trauma | T79.0XXA-T79.8XXA |
| Multiple Trauma | T07 |
| Spinal Cord Injury | S12.000A, S14.109A |
| **Transplantation, Failure & Complications** | |
| Transplantation | Z94x, Z51.89 |
| Complication of Transplanted Organs/Organ Rejection | T86.890-T86.90 |
| Renal Failure | N17.0-N19 |
| Liver Failure | K72.10-K72.90 |

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

This listing suggests conditions and related 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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