

Standard Stop Loss Disclosure Form Instructions for Completion

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as a part of "health care operations". The Company/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 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 risks 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 as of the date of this disclosure by making a thorough review of all applicable records. Such records shall include historical claims reports, disability records, current information from administrators, insurers, utilization management companies, managed care companies, and any Agent/Broker of the Plan Sponsor. In exchange, the Company will accept the liability for any truly unknown risks. The attached disclosure form must be completed and signed by the appropriate parties no more than [thirty (30)] days prior to the proposed Effective Date of stop loss coverage and received by the Company within [five (5)] days of completion.

Upon receipt of the completed disclosure, the Company will assess all data, new and previously reported, and will inform the producer in writing within [five (5)] days of any changes to the rates, factors or terms of coverage. The Company reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

List on the Disclosure Form all risks known to:

1. Be currently disabled, confined to a Medical Facility, or have been precertified within the last three months.
2. Have 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, and for which bills have been received by the Claims Administrator and entered into their Claims System.
3. Have been identified as a candidate for Case Management and 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.
4. Have been diagnosed, during the current plan year, with a condition represented by any of the ICD-9 codes contained in the attached list [and have also received medical services costing \$5,000 during the same period].

If the Plan Sponsor fails to disclose any risk known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then the Company will have no liability for claims on the risk not disclosed.

Important Disclaimer Note: This standard disclosure form is endorsed by Self-Insurance Institute of America, Inc. (July 2005). In endorsing this standard disclosure form, SIIA does not provide any opinion as to the validity/legality of collecting such data by insurers or others. This endorsement is solely related to the need for a standard format in which disclosure, if enforced by the industry, will enable employers/plan sponsors the opportunity to use a single form as an industry standard. SIIA assumes no liability, implied or otherwise, with regard to the use of this form. In this regard, parties utilizing this form are encouraged to seek their own legal counsel. SIIA does not provide legal counsel. www.siaa.org

Self-Insurance Institute of American (SIIA) Endorsed – September 2005

ICD-9 Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with or treated for any of the codes listed under the following categories during the current Benefit Period:

<u>001-139</u> <u>Infectious and Parasitic Diseases</u>	<u>460-519</u> <u>Diseases of the Respiratory System</u>
038-038.9 Septicemia	480-486 Pneumonia
042 AIDS / HIV	490-496 Chronic Obstructive Pulmonary Disease (COPD), etc.
070-070.9 Viral Hepatitis	515 Postinflammatory Pulmonary Fibrosis
	518-518.89 Pulmonary Collapse and/or Respiratory Failure
<u>140-239</u> <u>Neoplasms</u>	<u>520-579</u> <u>Diseases of the Digestive System</u>
140-149.9 Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx	555-555.9 Regional Enteritis (Crohn's Disease)
150-150.9 Malignant Neoplasm of Esophagus	560.0-560.9 Intestinal Obstruction
151-151.9 Malignant Neoplasm of Stomach	562.1 Diverticulitis of Colon
153-153.9 Malignant Neoplasm of Colon	567-567.9 Peritonitis
154-154.8 Malignant Neoplasm of Rectum	569.0-569.9 Other Disorders of Intestine
155-155.2 Malignant Neoplasm of Liver	570-571.9 Liver Diseases and Cirrhosis
157-157.9 Malignant Neoplasm of Pancreas	572.8 Other Sequela of Chronic Liver Disease
161-161.9 Malignant Neoplasm of Larynx	573-573.9 Other Liver Disorders
162-162.9 Malignant Neoplasm of Lung	577-577.9 Pancreas Diseases
170-170.9 Malignant Neoplasm of Bone	578-578.9 Gastrointestinal Hemorrhage
174-174.9 Malignant Neoplasm of Female Breast	
179-182.8 Malignant Neoplasm of Uterus or Cervix	<u>580-629</u> <u>Diseases of the Genitourinary System</u>
183-183.9 Malignant Neoplasm of Ovary	584-584.9 Acute Renal Failure
185 Malignant Neoplasm of Prostate	585 Chronic Renal Failure
186-186.9 Malignant Neoplasm of Testis	586 Renal Failure, Unspecified
188-189.9 Malignant Neoplasm of Bladder, Kidney, Urinary	588 Disorders resulting from impaired renal function
191-191.9 Malignant Neoplasm of Brain	592 Calculus of Kidney & Uerter
192-192.9 Malignant Neoplasm of Nervous System	
194-194.9 Malignant Neoplasm of Endocrine Glands	<u>630-677</u> <u>Complications of Pregnancy, Childbirth</u>
195-195.8 Malignant Neoplasm of Other Ill-Defined Sites	641.1 Placenta Previa
196-196.9 Secondary Malignant Neo. Lymph Nodes	642.5-642.7 Eclampsia, pre-eclampsia
197-197.8 Secondary Malignant Neo. Respty and Digestive Systems	644.0-644.2 Premature Labor
198-198.89 Secondary Malignant Neo. Other Specified Sites	648.0 Gestational Diabetes
200-208.9 Lymphoma and/or Leukemia	651 Multiple Gestation
235 Neoplasm Uncertain Behavior	654.5 Cervical Incompetence
239.2 Neoplasm Unspecified Nature – Bone, Skin	
<u>240-279</u> <u>Endocrine, Nutritional, Metabolic, Immunity</u>	<u>710-739</u> <u>Diseases of the Musculoskeletal System and Connective Tissue</u>
250-250.9 Diabetes	715.0-715.9 Osteoarthritis
277.0 Cystic Fibrosis	721.3 Lumbosacrel Spondylosis
278.0 Obesity/Hyperalimnt	722.0-722.9 Intervertebral Disc Disorders
<u>280-289</u> <u>Diseases of the Blood and Blood-Forming Organs</u>	730-730.9 Osteomyelitis and/or Periostitis
282.6 Sickle-Cell Anemia	737.3 Kyphoscoliosis and scoliosis
284.9 Aplastic Anemia NOS	
286-286.9 Coagulation Defects and/or Hemophilia	<u>740-759</u> <u>Congenital Anomalies</u>
	747.2 Aortic Atresia / Stenosis
<u>320-389</u> <u>Diseases of the Nervous System and Sense Organs</u>	751.6 Biliary Atresia
330 Cerebral degenerations	759-759.9 Other and Unspecified Congenital Anomalies
344.0-344.09 Quadriplegia and Quadriparesis	
331.0-331.9 Reye's Syndrome	<u>760-779</u> <u>Conditions Originating in the Perinatal Period</u>
344.1 Paraplegia	765-765.1 Prematurity
348.0-348.9 Encephalopathy	769 Respiratory Distress Syndrome
357, 358 Neuropathy / Myasthenia Gravis	770.0-770.9 Other Respiratory Conditions of Newborn
<u>390-459</u> <u>Diseases of the Circulatory System</u>	<u>780-799</u> <u>Symptoms, Signs, and Ill-Defined Conditions</u>
410-410.9 Acute Myocardial Infarction	785-785.9 Symptoms Involving Cardiovascular System
411-411.89 Acute and Subacute Ischemic Heart Disease	786.5-786.59 Chest Pain
414-414.05 Coronary Atherosclerosis (ASHD)	
415-415.19 Acute Pulmonary Heart Disease	<u>800-999</u> <u>Injury and Poisoning</u>
416-416.9 Chronic Pulmonary Heart Disease	800-804.9 Fracture of Skull
417.1 Aneurysm of Pulmonary Artery	805-805.9 Fracture of Vertebral Column
421-421.9 Acute and Subacute Endocarditis	806-806.9 Fracture of Vertebral Column with Spinal Cord Injury
424-424.9 Valve Disorders	828-828.1 Multiple Fractures
425-425.9 Cardiomyopathy	853-854.1 Intracranial Injury
426-426.9 Conduction Disorders	869-869.1 Internal Injury
427-427.9 Cardiac Dysrhythmias	887-887.7 Traumatic Amputation of Arm and Hand
428-428.9 Heart Failure	897-897.7 Traumatic Amputation of Leg
430, 431 Subarachnoid / Intracerebral Hemorrhage	949-949.5 Burns
434.9 Occlusion of Cerebral Arteries	952-952.9 Spinal Cord Injury
436 Acute Cerebrovascular Accident (CVA)	996-997.0 Complications peculiar to certain specified conditions
440-441.9 Atherosclerosis / Aortic Aneurysm	V23 Supervision of High Risk Pregnancy
	V42 – V58.9 Transplants, etc

Self-Insurance Institute of America (SIIA) Endorsed - September 2005

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue
New York, New York 10022

DISCLOSURE STATEMENT

As an integral part of the application for excess loss coverage, Standard Security Life Insurance Company of New York (the Company) and **Phoenix Excess Risk Underwriters, LLC** require that the applicant provide information concerning the following on all known individuals no earlier than **30** days prior to the requested effective date:

- a) Individuals with ongoing or potential claims exceeding 50% of the requested specific deductible amount, during the last 12 months.
- b) Individuals currently confined to a hospital or other health care facility, or currently approved for a future hospital or other health care facility admission.
- c) Employees not actively at work on a full time basis as defined in your Plan, or dependents who are confined to a hospital, institution, or home or otherwise unable to perform the duties of a like person of the same age and sex and are in good health as of the signature date of this statement.
- d) Any other individuals with claims that may be potentially serious, regardless of current claim amount.

Please attach the following information:

- NAME
- DATE OF BIRTH
- GENDER
- Status: EMPLOYEE, DEPENDENT, RETIREE, COBRA BEN.
- DIAGNOSIS
- PROGNOSIS
- TRANSPLANT CANDIDATE
- DATE OF DISABILITY
- DATE EXPECTED RTW
- COBRA EFFECTIVE / END DATES
- PAID CLAIMS
- ADDITIONAL KNOWN CLAIMS

The Employer named below, through its authorized person, hereby represents that the attached information is true, complete and accurate to the best of its knowledge and belief after due inquiry and that of its agents, administrators, and brokers, and that nothing has been knowingly or intentionally omitted. The Employer agrees to the following: 1) if the information provided in this statement is not true, complete and accurate, the excess loss coverage may be re-rated from the effective date of coverage, 2) any individual who has incurred a serious claim may be excluded from coverage, unless disclosed by Employer and approved in writing by the Company and **Phoenix Excess Risk Underwriters, LLC** The Company reserves the right to set a higher aggregate or specific deductible on, or limit the benefit eligibility period or other policy benefits for, any individual who has or should have been listed above. The Employer represents that its administrator, utilization review vendor and large claim management service organization participated in the collection of the above data.

The Company and **Phoenix Excess Risk Underwriters, LLC** shall use the information requested herein solely for the purpose of evaluating the acceptability of this risk and shall not disclose any nonpublic personal information collected except in evaluating the acceptability of this risk.

EMPLOYER: _____ ADMINISTRATOR: _____

Date of Disclosure: _____ Date of Disclosure: _____

Authorized Representative: _____ Authorized Representative: _____

Title: _____ Signature: _____

Signature: _____