



# PERICO LIFE INSURANCE COMPANY

## Excess Loss Insurance Disclosure Form

Group Name \_\_\_\_\_ Address (No P.O. Box) \_\_\_\_\_

This Disclosure Form is an integral part of your request for and/or renewal of Excess Loss Insurance. It will be relied upon by Perico Life Insurance Company in issuing a Stop Loss Insurance Contract. This Disclosure Form must be completed no earlier than the later of either a) thirty (30) days prior to the proposed Contract Effective or Renewal Date, or b) the date the premium is received by Perico Life Insurance Company. This form must be forwarded to Perico Life Insurance Company within fifteen days of completion by the Plan Sponsor. The Excess Loss Insurance Proposal requires the Plan Sponsor to disclose employees who are not actively at work and dependents that are hospital-confined or totally disabled on the Disclosure Date. Furthermore, the Plan Sponsor is required to disclose the same information for covered individuals whose paid claims under the Plan have exceeded 50% of the requested Specific Retention Amount during the twelve (12) month period immediately preceding the Disclosure Date, or whose claims are expected to exceed 50% of the requested Specific Retention Amount.

**The information provided on this Disclosure Form must be current as of the date the form is signed. It must be completed in its entirety.** Perico Life Insurance Company reserves the right to withdraw its quote if the signed Disclosure Form is not completed and returned to us within fifteen (15) days following the date the Disclosure Form is signed.

Please answer the following questions using **Page 2** to fully explain any **YES** answers:

1. Are there any participants (employees, dependents or COBRA beneficiaries) who, during the preceding twelve (12) month period, incurred claims in excess of 50% of the Specific Retention Amount whether paid, pending, or denied?.....  Yes  No
2. a. Are there any participants (employee, dependents or COBRA beneficiaries) who are expected to be absent from work due to work related or non-work related Disability on the Contract Period Effective/Renewal Date?.....  Yes  No
  - b. Are there any dependents, including dependent children, who are currently disabled or who are covered under the Plan under a disabled or handicapped child extension provision?.....  Yes  No
3. Are there any participants (employee, dependents or COBRA beneficiaries) who are or have been confined in the hospital or medical facility within the preceding twelve (12) months for five (5) or more consecutive days?.....  Yes  No
4. a. Are there any participants (employee, dependents or COBRA beneficiaries) for whom a hospital requested pre-certification within the past twelve (12) months for five (5) or more consecutive days?.....  Yes  No
  - b. Are there any participants (employees, dependents or COBRA beneficiaries) who were in case management in the past 12 months or who are currently in case management?.....  Yes  No
5. Are there any participants with a history or a current diagnosis of any serious disease or disorder such as BUT NOT LIMITED TO cancer, diabetes, heart disease, renal failure, AIDS or AIDS Related Complex (ARC), leukemia, muscular/neuro diseases, high risk pregnancy and potential organ transplants, etc.?.....  Yes  No
6. Are there any other serious potential shock loss claims (i.e. claims which may reasonably be assumed will exceed 50% of the Specific Retention Amount) in the next twelve (12) months?.....  Yes  No
7. If the Specific Retention Amount is \$15,000 or less, is any covered person currently pregnant? .....  Yes  No  
If so, provide a list including name, expected date of delivery, nature of pregnancy (normal, high risk) and expected means of delivery (normal, c-section).



The Plan Sponsor acknowledges by signing below that they have contacted their Utilization Review/Large Case Management Company, Third Party Administrator, Human Resources Manager and any other applicable source to verify the above data. The Plan Sponsor acknowledges by signing below that attachments to the Disclosure Form will only be accepted if noted as such and signed and dated by the Plan Sponsor. **The Plan Sponsor acknowledges by signing below that Excess Loss Insurance coverage is available to those individuals who are disabled and not actively at work or are unable to perform the same duties of an individual of the same age and sex of the effective date of coverage only if such individuals are disclosed herein.**

It is agreed that the statements in this Disclosure Form plus any and all materials submitted to Perico Life Insurance Company for this group are hereby warranted by you. All representations shall be deemed material to acceptance of the risk by Perico Life Insurance Company and the Excess Loss Contract is to be issued in reliance of the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Excess Loss Contract, would affect the premium rates, factors, terms or conditions for coverage thereunder, Perico Life Insurance Company will have the right to revise the premium rates, factors, terms or conditions as of the effective date of the Excess Loss Contract by providing written notice to you. Any fraudulent statement will render the Stop Loss Contract null and void and claims, if any, will be forfeited. Acceptance of all the above understandings is represented by the signatures below.

Disclosure Date: \_\_\_\_\_

Plan Sponsor: \_\_\_\_\_

Third Party Administrator: \_\_\_\_\_

Plan Sponsor Federal Tax ID #: \_\_\_\_\_

Authorized Person Signature: \_\_\_\_\_

Authorized Person Signature: \_\_\_\_\_

Authorized Person (Please Print): \_\_\_\_\_

Authorized Person (Please Print): \_\_\_\_\_

Agent Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Agent Name (Please Print): \_\_\_\_\_

Agency Name (if applicable) \_\_\_\_\_

Agent Address: \_\_\_\_\_

Agent Phone No. \_\_\_\_\_

Agent E-mail: \_\_\_\_\_