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:

_____
_____
_____
_____

I have reviewed the completed form and the information given is complete and accurate, to the best of my knowledge and belief. I 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that if the information is not complete and accurate, the Excess Loss coverage proposed may be reevaluated, rerated, rescinded or declined and **Participants** not disclosed may be denied coverage or individually underwritten retroactively to the Effective Date.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 Payor/TPA: _____

Officer's Signature: _____ Signature: _____

Name & Title: _____ Name & Title: _____

Date: _____ Date: _____