TPAC UNDERWRITERS, INC.
DISCLOSURE STATEMENT

Prospective Contractholder: _____

Proposed Effective Date: _____ Disclosure Amount ($25K) or Specific Deductible: _____

A. PLAN PARTICIPATION

_____ Number of employees eligible to participate in the benefit plan

_____ Total number of eligible employees not participating in the current benefit plan (including those with other coverage)

_____ Number of eligible employees not participating in the current benefit plan due to other coverage

B. GROUP DISCLOSURE

Do you, as the Prospective Contractholder, know of any Covered Employee, Covered Dependent, participating COBRA beneficiary, retiree or person(s) to be covered under the Prospective Contractholder's benefit plan who:

☐ Yes ☐ No Has ongoing medical and/or Rx claims that have exceeded 50% of the disclosure amount or the specific deductible during the last 12 months, or have the potential to exceed 50% of the disclosure amount or specific deductible within the next 12 months?

☐ Yes ☐ No Is currently hospital or institution confined, or expected to be confined within 90 days of the Effective Date?

☐ Yes ☐ No Is currently under case management or is a candidate for case management?

☐ Yes ☐ No Is disabled as of the date of this disclosure?

☐ Yes ☐ No Is retired or will be retired as of the Effective date?

☐ Yes ☐ No Is currently covered under COBRA or is eligible to be covered under COBRA?

☐ Yes ☐ No Have your employees filled out medical applications for any carrier for an effective date within 6 months of the Proposed Effective Date? If yes, attach copies of these applications if not previously disclosed.

C. HIGH RISK DIAGNOSIS LIST

Do you know of any Covered Employee or Dependent or potential Plan Participant who, within the last 24 months, was treated for or diagnosed with a potentially high risk diagnosis such as those on the following list?

	YES	NO		YES	NO
HIV/AIDS or other Immune System Disorder	☐	☐	Cancer, Leukemia, Multiple Myeloma, Lymphoma or Tumor(s)	☐	☐
Heart Attack or other Heart/Vascular Disorder	☐	☐	Lupus, Scleroderma or other Auto Immune Disorder	☐	☐
Hemophilia or Other Blood Clotting Disorder	☐	☐	Pancreas or Kidney Disorder such as End Stage Renal Disease	☐	☐
Aplastic Anemia or Sickle Cell Anemia	☐	☐	Cirrhosis, Hepatitis or other Liver Disorder	☐	☐
Thrombocytopenia, Agranulocytosis or other Anemia	☐	☐	Diabetes	☐	☐
Stroke, Aneurysms or other Cerebrovascular Disorder	☐	☐	Pituitary, Adrenal or other Gland Disorder	☐	☐
Cystic Fibrosis or other Respiratory Disorder	☐	☐	Crohn's, Diverticulitis or other Intestinal Disorder	☐	☐
Emphysema, COPD or Chronic Bronchitis	☐	☐	Arthritis, Rheumatism or other Bone/Joint Disorder	☐	☐
Parkinson's Disease, Cerebral Palsy, Epilepsy or ALS	☐	☐	Back or Spine Disorder, Paralysis, Quadriplegia or Paraplegia	☐	☐
Other Brain Disorder such as cerebral degenerations/neuropathy	☐	☐	Genetic or Congenital Disorder or other Birth Defect	☐	☐
Multiple Sclerosis or Guillain-Barre' Syndrome	☐	☐	Mental/Nervous Disorder or Alcohol/Substance Abuse	☐	☐
Major Trauma, Burn or Head Injury	☐	☐	Transplants of any kind	☐	☐
Pregnancy complications, multiple gestation or In Vitro Fertilization	☐	☐	Perinatal complications such as prematurity or respiratory distress	☐	☐
			Other High Risk (not listed here)	☐	☐

D. DETAIL INFORMATION

If you answered Yes to any of the questions in sections B or C please use the space below to list the requested information.

DOB	Sex	EE, Sp or Ch	(A)ctive (C)OBRA (R)et or (T)ermed	Term Date	Diagnosis	Most Recent Date of Service	Expenses Incurred Over last 12 months

(If more space is needed, please attach a separate sheet.)

E. SIGNATURES

As the Prospective Contractholder, we hereby warrant and represent that the above is complete and accurate and that nothing has been omitted to our knowledge. We also acknowledge that any individual known to us, or our administrator, not appropriately disclosed to and approved by TPAC Underwriters, Inc. might be excluded from Stop Loss Insurance.

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Prospective Contractholder as a part of "health care operations". TPAC Underwriters, Inc. (TPAC) 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.

TPAC will rely upon the information provided on this form, which will become part of the Application for stop loss coverage. The purpose of the form is to allow TPAC to take underwriting action on all known risks in the categories listed in section C above. It is the Prospective Contractholder'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.

Upon receipt of the completed disclosure, TPAC will assess all data, new and previously reported, and will inform the producer in writing of any changes to the rates, factors or terms of coverage. TPAC reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process. If the Prospective Contractholder fails to disclose any risk known to fall into one of the categories listed above, either intentionally or because a thorough review of all records was not conducted, then TPAC and its carrier will have no liability for claims on the risk not disclosed.

Contractholder: _____ Agency Name: _____ Claims Administrator: _____

Signature: _____ Signature: _____ Signature: _____

Name: _____ Name: _____ Name: _____

Title: _____ Title: _____ Title: _____

Date: _____ Date: _____ Date: _____