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# BANKERS INSURANCE COMPANY

11101 ROOSEVELT BOULEVARD. ST. PETERSBURG, FLORIDA 33716

## EMPLOYER STOP LOSS - Enrollment Application



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**BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH BANKERS INSURANCE COMPANY (THE "COMPANY")**

### APPLICATION INSTRUCTIONS:

1. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

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### I. GENERAL INFORMATION

1. Name of Applicant: \_\_\_\_\_  
Full Legal Name of Employer
2. Principal Office Location: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_
3. Web address: \_\_\_\_\_
4. Name and Address of Primary Contact: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_
5. Other Location(s):      Yes      No

If Yes, please give name and complete address of all employees, including total number, at each location:

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### II. SPECIFIC INFORMATION

1. Enter the full name of your benefit plan(s): (A copy of such executed benefit plan(s), including all amendments, must be attached.)  
\_\_\_\_\_
2. Nature of Applicant's Primary Business: (SIC Code) \_\_\_\_\_
3. Federal Employer's Tax I.D. #: \_\_\_\_\_  
Number of Years in Business: \_\_\_\_\_  
 Corporation                       Partnership                       Proprietorship
4. Estimated Initial Enrollment:  
\_\_\_\_\_ Single/Employee only                      \_\_\_\_\_ COBRA Beneficiaries  
\_\_\_\_\_ Employee and Spouse                      \_\_\_\_\_ Retired Employees  
\_\_\_\_\_ Employee and Child(ren)                      \_\_\_\_\_ Family (Employee/Spouse/Children)
5. Proposed Effective Date: \_\_\_\_\_



**IV. REQUESTED COVERAGE - Continued**

**B. [Aggregate Stop Loss Insurance Requested:**

- 1. Requested under the Policy:  Yes  No
- 2. Requested Coverage to Include: Medical  Yes  No  
Prescription Drug  Yes  No
- 3. Requested Coverage Incurred From: \_\_\_\_\_ to: \_\_\_\_\_
- 4. Run-in Limit (if applicable):
  - A. Covered services incurred from: \_\_\_\_\_ to: \_\_\_\_\_
  - B. Not to exceed: \$ \_\_\_\_\_
- 5. Minimum Aggregate retention Per Policy Period: \$ \_\_\_\_\_
- 6. Monthly Aggregate Factors: \$ \_\_\_\_\_ Per Single/Employee Only Covered Unit  
\$ \_\_\_\_\_ Per Employee and Spouse Covered Unit  
\$ \_\_\_\_\_ Per Employee and Child(ren) Covered Unit  
\$ \_\_\_\_\_ Per Family (Employee/Spouse/Children) Covered Unit
- 7. Paid by the Insured From: \_\_\_\_\_ to: \_\_\_\_\_
- 8. Claim Reporting Deadline: \_\_\_\_\_
- 9. Maximum Aggregate Benefit Per Policy Period: \$ \_\_\_\_\_
- 10. Aggregate Monthly Premium Rates: \$ \_\_\_\_\_ Per Single/Employee Only Covered Unit  
\$ \_\_\_\_\_ Per Employee and Spouse Covered Unit  
\$ \_\_\_\_\_ Per Employee and Child(ren) Covered Unit  
\$ \_\_\_\_\_ Per Family (Employee/Spouse/Children) Covered Unit]

**C. Additional Options Requested:**

- 1. Terminal Liability Option Requested:  Yes  No
- 2. Aggregate Advance Funding Option Requested:  Yes  No
- 3. \$ \_\_\_\_\_ Terminal Liability Risk premium Per Employee
- 4. \$ \_\_\_\_\_ Aggregate Advance Funding Option
- 5. Terminal Liability Attachment Factors: \$ \_\_\_\_\_ Per Single/Employee Only Covered Unit  
\$ \_\_\_\_\_ Per Employee and Spouse Covered Unit  
\$ \_\_\_\_\_ Per Employee and Child(ren) Covered Unit  
\$ \_\_\_\_\_ Per Family (Employee/Spouse/Children) Covered Unit]

**D. Representation: Prior Knowledge of Facts/Circumstances/Situations:**

No person or entity proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claims that would fall within the scope of the proposed coverage except:

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Without prejudice to any other rights and remedies of the Company, the Applicant understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed above, any claim or action arising from such fact, circumstance, or situation is excluded from the proposed coverage if a policy is issued by the Company.

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**V. MATERIAL CHANGE:**

If there is any material change in the answers to the questions in this Application before the policy inception date, the Applicant must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

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**VI. NOTICES:**

Receipt of any money in connection with this Application shall not constitute an acceptance of liability. In the event the Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

The Applicant's submission of this Application does not obligate the Company to issue a policy. If the Application for insurance is approved, the Applicant will be advised. The Company is authorized to make any inquiries required or deemed necessary in relation to review of this Application.

**Notice to Florida Applicants:**

Any person who, knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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**VII. DECLARATION AND SIGNATURE:**

For the purposes of this Application, the undersigned authorized representative of the person(s) and company proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application for Stop Loss Insurance and any attached documentation are true and complete. The undersigned further agrees that this Application and any attachments shall form and be a part of the contract should the Application for insurance be approved by the Insurer. In issuing the insurance coverage, the insurer shall have relied upon and based their approval for coverage on the documentation, application and statements as contained herein.

Any information requested in conjunction with review and approval of this Application is for underwriting purposes only. It does not serve as a notice of claim to the company or any other entity.

This Application must be signed by the President and Chief Financial Officer of the insured acting as the authorized representatives.

Date	Signature	Title
_____	_____	_____
_____	_____	_____

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**PRODUCER INFORMATION**

Agent Name: \_\_\_\_\_ Agent Signature: \_\_\_\_\_  
Agent Florida License#: \_\_\_\_\_ Date: \_\_\_\_\_

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**HOME OFFICE USE ONLY:**

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_

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# **BANKERS INSURANCE COMPANY**

**11101 Roosevelt Boulevard, St. Petersburg, FL 33716**  
**EMPLOYER STOP LOSS - Disclosure Statement**

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Bankers Insurance Company (“Bankers”) requires that all employees and dependents eligible for coverage under the plan sponsor’s self-funded health plan who meet any of the criteria outlined below be disclosed to Bankers. The Insured is required to contact their current claims administrator and utilization management company in order to obtain precertification, case/transplant management and claims file data. This Disclosure Statement may be completed no earlier than 60 days prior to the effective date and no later than 15 days after the effective date of the Stop Loss Policy with Bankers Insurance Company.

Disclosure information is required for the following:

1. Any employees or dependents with medical expenses which exceed the lesser of 50% of the Specific Stop Loss Amount or \$25,000 during the twelve (12) month period prior to the completion of this Disclosure Statement. This includes:
  - Employees or dependents who are or are expected to be absent from work due to work related or non-work related disability on the effective date of coverage; and
  - Employees or dependents who are or have been confined to a hospital or medical facility within 30 days prior to the date of completion of this statement or who have been approved for a confinement within 90 days after the effective date; and
  - Dependent children over the normal termination age who are covered under a disabled or handicapped child extension provision; and
  - COBRA employees or dependents.

**OR**

2. Any employees or dependents diagnosed with the following serious diseases/disorders:

<u>ICD-9 Code</u>	<u>Diagnosis</u>	<u>ICD-9 Code</u>	<u>Diagnosis</u>	<u>ICD-9 Code</u>	<u>Diagnosis</u>
<b>141-208</b>	Cancer/Malignant Neoplasm/Leukemia	<b>416-429</b>	Heart/Lung Disease	<b>760-779</b>	Newborn Complications
<b>235-239</b>	Neoplasm of Uncertain behavior	<b>425</b>	Cardiomyopathy	<b>800-806</b>	Fracture of the Skull/Neck/Trunk
<b>272.7</b>	Gaucher’s Disease	<b>430-438</b>	Cerebral Vascular Disease/Stroke	<b>850.4-854</b>	Intracranial Injury
<b>277</b>	Cystic Fibrosis	<b>570-573</b>	Chronic Liver Disease	<b>941-949</b>	Severe Burns
<b>286</b>	Hemophilia	<b>577</b>	Pancreatitis	<b>952-953</b>	Spinal Cord Injury
<b>335.2</b>	Anterior Horn Cell Disease	<b>584-587</b>	Acute/Chronic Renal Disease	<b>996</b>	Complications of Organ Transplant

**AND**

3. Any employees or dependents who have had an organ transplant or bone marrow transplant or who have been listed for an organ transplant or bone marrow transplant.

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



# BANKERS INSURANCE COMPANY

[11101 ROOSEVELT BOULEVARD. ST. PETERSBURG, FLORIDA 33716]

## EMPLOYER STOP LOSS - Enrollment Application - Individual



### COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:

Employee Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_ Social Security Number \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_ Marital Status \_\_\_\_\_ Are you and your dependents US citizens? \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer Name \_\_\_\_\_ Work Telephone \_\_\_\_\_ Occupation \_\_\_\_\_  
 Hire Date \_\_\_\_\_ Salary \_\_\_\_\_ Hours Worked \_\_\_\_\_ Is your spouse Employed? \_\_\_\_\_

### COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:

Spouse: Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_ Height Weight \_\_\_\_\_  
 Social Security Number \_\_\_\_\_ Occupation \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security Number \_\_\_\_\_  
 Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Social Security Number \_\_\_\_\_

### PRIOR MEDICAL COVERAGE

Are you or any applicant on this form currently covered under a health plan or been covered within the last 63 days?  
 .....  Yes  No

If "yes", please list applicant(s) covered: \_\_\_\_\_

Please attach your prior Certificate of Creditable Coverage and complete the information below:

Name and phone number of current/prior health insurance Carrier: \_\_\_\_\_

Policy # \_\_\_\_\_ Effective date of coverage \_\_\_\_\_ Termination date \_\_\_\_\_

What type of coverage was Your or Your Dependents last plan?  
 .....  Employer Based Group  Individual  COBRA  Other \_\_\_\_\_

**IMPORTANT:** Do not cancel any existing health coverage until you have received written notification of your acceptance by Bankers Health Plans

### ADDITIONAL QUESTIONS

Have you or any of your dependents had any form of health insurance denied, rated-up, changed or rescinded, or had any conditions excluded by rider? .....  Yes  No

If Yes, please explain: \_\_\_\_\_

### ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS (Required for all applicants applying for coverage:

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependents. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Based on a physician's advice, diagnosis or treatment, are all proposed insureds now in good health and free from any physical or mental disease or defects? .....                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. To the best of your knowledge, is the proposed insured, spouse, or any dependent child, whether to be covered or not, currently pregnant or an expectant parent or have an adoption pending? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. In the past 5 years have you or any person proposed for coverage been treated for or are you (they) currently undergoing infertility treatment? .....  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**MEDICAL HISTORY QUESTIONS - Continued**

4. Has any person proposed for coverage tested positive for exposure to the HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) cause by the HIV infection or other sickness or condition derived from such infection? .....  Yes  No
5. Within the past 5 years have you or any person proposed for coverage been diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, degenerative joint disease of the knee, high blood pressure, diabetes, alcohol abuse or chemical dependency? .....  Yes  No
6. In the last 5 years have you any person proposed for coverage been diagnosed by a physician, treated by a physician, or had a physician recommend testing for any:
- a. Disease or disorder of the heart, blood or circulatory system; stroke; cancer; diabetes? .....  Yes  No
- b. Disease or disorder of the respiratory system, including emphysema or asthma? .....  Yes  No
- c. Disease or disorder of the rectum, kidney, prostate, intestine, liver, or hepatitis? .....  Yes  No
- d. Disease or disorder of the nervous system, brain, back or spine; paralysis; stroke; severe arthritis; epilepsy; mental or nervous disorder; alcohol or drug abuse? .....  Yes  No
7. Has any person proposed for coverage been hospitalized in the last 12 months or been recommended for medical or surgical treatment, testing, or hospitalization by a physician that has not yet been done? .....  Yes  No
8. Within the last 24 months, have you or any person proposed for coverage consulted a physician or practitioner or had a complete physical examination (including a gynecological exam and emergency room visits)? .....  Yes  No
9. Has any person proposed for coverage ever had a mammogram within the last 2 years? .....  Yes  No
10. FEMALES Only: Have you or any female proposed for coverage had an abnormal Pap Smear/Pelvic Exam? .....  Yes  No

11. List all current physician prescribed medications (use a separate sheet of paper for additional information).

Proposed Insured	Medication	Reason for Taking/Condition Treated	Date Prescribed	Date Last Taken

12. Within the last 5 years, have you or any persons proposed for coverage used tobacco products (i.e. cigarettes, cigars, pipes, smokeless tobacco products, chewing tobacco, etc.)? .....  Yes  No

Proposed Insured	Tobacco Product Used	Date Started Use	Date Stopped Use

**Provide details to "YES" answer to Questions 2 - 10 (use a separate sheet of paper for additional information).**

Question	Proposed Insured	Details

Question	Proposed Insured	Details

**Waiver of Participation**

Each eligible employee who chooses not to apply for coverage for self, spouse, or dependent children must complete this section.

I voluntarily waive all coverage for:

.....  Myself  My spouse  My spouse and dependent children  My dependent child(ren)

Reason for waiving coverage:  Covered under another plan  Covered under spouse's plan  Other \_\_\_\_\_

Indicate type of coverage:

.....  Individual  Group  Medicare  Other  COBRA \_\_\_/\_\_\_/\_\_\_ Date COBRA coverage began

By my signature below, I hereby certify that I have been offered the opportunity to participate in my employer-sponsored health plan. The benefits which are available have been thoroughly explained to me. I understand that if I wish to apply for coverage at a later date, I must furnish evidence of insurability before I can become insured. As a late entrant, I understand that coverage may be postponed or subject to pre-existing condition limitations, as permitted by law.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Agreement:**

1. I represent, to the best of my belief, that all statements and answers contained in this application and in any supplements required by Bankers Health Plans (BHP) are complete, true, and correct. I agree to immediately notify BHP of any changes in any of the information contained in this form, which may occur prior to the approval of coverage.
2. I expressly agree that no insurance is in effect as a result of this application unless: (a) the application is approved by BHP; and (b) a policy has been issued by BHP; and (c) the policy has been manually received and accepted by the policyholder.
3. I hereby request coverage under the plan and understand that if the coverage applied for becomes effective, I agree to all terms of the plan. I understand that health plan benefits are limited for pre-existing conditions.
4. I understand that the plan is an employee health and welfare benefit plan created under the Employee Retirement Income Security ACT (ERISA) of 1974 and subject to the rules and regulations adopted by the United States Department of Labor and is not insurance subject to the laws of the state in which I work or reside. Benefits are effective only after approval by BHP or its designee and satisfaction of any probationary period.

**Authorization:** I (We) hereby authorize any hospital, Veterans Administration Hospital, physician, company, institution or person who has attended or examined any Proposed Insured, to disclose, when requested by Bankers Health Plans or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I (We) hereby, further authorize any past or present employer, or consumer reporting agency to release information when requested by Bankers Health Plans or its representative. I (We) understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected under federal privacy regulations. I (We) may revoke this authorization, by notifying Bankers Health Plans, in writing, of my (our) desire to revoke it. However, I (We) understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. This authorization will expire One Hundred Eighty (180) days from the date of my (our) signature(s). A photocopy of this authorization shall be considered as valid as the original. **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony in the third degree.**

I (We) hereby declare the application was signed and dated at: \_\_\_\_\_ on \_\_\_ / \_\_\_ / 20\_\_\_  
City/State Month/Day

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Spouse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**HOME OFFICE USE ONLY:**

**Reviewed:** \_\_\_\_\_

**Date:** \_\_\_\_\_