PENNSYLVANIA MANUFACTURERS' ASSOCIATION INSURANCE COMPANY

380 Sentry Parkway, Blue Bell, PA 19422
610-397-5462

STOP LOSS INSURANCE POLICY

APPLICATION

The undersigned Applicant requests Stop Loss Insurance provided by Pennsylvania Manufacturers' Association Insurance Company ("Company"). If this Application is accepted and approved by the Company, the Applicant agrees to be bound by the terms and conditions of the Stop Loss Insurance Policy as issued by the Company. This Application shall be deemed attached to and becomes part of the Policy issued.

Legal Business Name**:** [legal business name]

Principal Address: [address]
[city, state, zip]

Subsidiaries and Associated Entities to be included in the Policy coverage:
[name(s)]

Requested Policy Term [date] through [date]

[Claim Administrator(s): [Name]
[Contact Name]
[address]
[city, state, zip]]

[Cost Containment Program: [Name]
[Contact Name]
[address]
[city, state, zip]]

[Prescription Benefit Manager: [Name]
[Contact Name]
[address]
[city, state, zip]]

[Provider Network(s): [Name]
[state]]

[Referenced Based Pricing Vendor: [Name]
[state]]

Covered Units (initial enrollment):
[Employee [100]]
[Employee & Spouse [0]]
[Employee & Child(ren) [0]]

[Employee & Family [0]]
[Composite [0]]
[Member [0]]

Other groups considered as covered Employees:

[Retirees (under age 65)]
[Retirees (age 65 and over)]
[COBRA Continuees]
[Employees on Medical or Family Leave]
[Disabled Employees]
[Employees not Actively at Work]
[Others]

STOP LOSS INSURANCE:

[A.] [AGGREGATE COVERAGE SCHEDULE Yes ___ No___

For all Eligible Claims Expenses except those to which any Other Limitation applies:

1. Benefit Period

   Eligible Claims Expenses Incurred from [date] through [date] and Paid from [date] through [date]

2. Aggregate Eligible Claims Expenses include:

[Medical	Yes/No]
[Vision	Yes/No]
[Dental	Yes/No]
[Prescription Drug Plan	Yes/No]
[Other:_____]	

3. Aggregate Payable Percentage: [ ]

4. Minimum Annual Aggregate Attachment Point: $[xx,xxx.xx]

5. Maximum Aggregate Reimbursement (per Policy Term): $[xx,xxx.xx]

6. Monthly Aggregate Factors per Covered Unit

Covered Unit	Medical [including [Vision] [Dental] [Prescription Drug]]	[Vision]	[Dental]	[Prescription Drug]	[Other]	[Monthly Expected Claims]
[Employee [Plan A]]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee Plan B]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Spouse [Plan A]]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Spouse Plan B]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Child(ren) [Plan A]]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Child(ren) Plan B]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Family [Plan A]]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Employee & Family Plan B]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Member [Plan A]]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]
[Member Plan B]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]	$[ ]

7. Other Limitations [ ]
8. Aggregate Claim Limit Per Covered Person:

Entire Group	$[xx,xxx.xx]

]

[B.] [SPECIFIC COVERAGE SCHEDULE Yes ___ No___

For all Eligible Claims Expenses except those to which a Special Risk Limitation applies:

1. Benefit Period:

   Eligible Claims Expenses Incurred from [date] through [date] and Paid from [date] through [date]

2. Specific Eligible Claims Expenses Include:

   [Medical Yes/No]
   [Vision Yes/No]
   [Dental Yes/No]
   [Prescription Drug Plan Yes/No]
   [Other:_____]

3. Specific Attachment Point [per Specific Attachment Point Class] [per Covered Person] [per Family] (other than any Covered Persons or Classes named below to which a Special Risk Limitation applies):

   Entire Group $[xx,xxx.xx] [ ]%]

4. Aggregating Specific Deductible

	Aggregating Specific Deductible
Entire group	$[xx.xxx.xx]

5. Specific Payable Percentage: [ ]%

6. Maximum Specific Benefit Limits (in excess of the Specific Attachment Point)

   a) Specific Reimbursement Percentage Payable after Specific Attachment Point: [100%]

   b) Specific Annual Maximum Reimbursement per Covered Person:
   Entire Group $[xx,xxx.xx] [unlimited]]

   c) Specific Lifetime Maximum Limit per Covered Person:
   Entire Group $[xx,xxx.xx] [unlimited]]

[7. Run-In Limit: $[xx,xxx.xx] of plan benefits Incurred [per Covered Person] prior to the Policy Effective Date.]

[8.] [Run-Out Limit: $[xx,xxx.xx] of plan benefits Paid [per Covered Person] but after the Policy Termination Date.]

[9.] [Special Risk Limitations. [Classes][Covered Persons] subject to the Individual Specific Attachment Point (separate from item 3 above) [and] [Benefit Period limitation] shown below:

	Individual Specific Attachment Point	[Benefit Period limitation]
[Covered Person Name/Identifier	$[xx,xxx.xx]	[period from – to]]

[Special Risk Limitations. [Classes][Covered Persons] subject to the Contingent Specific Attachment Point for the service, procedure, or therapy shown below:

	Contingent Specific Attachment Point	[Service, Procedure, or Therapy]
[Covered Person Name/Identifier	$[xx,xxx.xx]]	

[10]. Other Limitations [ ]
]

[C.] Premium

Premium Due and Payable: the 1st day of each month, subject to Grace Period

[Minimum Annual Specific Premium: $[ ]]

[Minimum Annual Aggregate Premium: $[ ]]

[Specific Premium Rate per Policy Month per Covered Unit:

[Employee $[ ]]

[Employee & Spouse $[ ]]

[Employee & Child $[ ]]

[Employee & Family $[ ]]

[Aggregate Premium Rate per Policy Month per Covered Unit:

[Composite $[ ]]

The Specific Premium Rate per Policy Month and the Aggregate Premium Rate per Policy Month per Covered Unit only apply to the Policy Term and Benefit Period shown in this Schedule.

[[D.] Endorsements attached to the Policy:

The following endorsement(s) are included:

[Administrative Endorsement]

[Aggregate Accommodation Benefit Endorsement]

[Aggregate Terminal Liability Endorsement]

[Bill Review Endorsement]

[Carve Out Program Endorsement]

[Cell and Gene Therapy Endorsement]

[Cost Containment Program Endorsement]

[Domestic Reimbursement Endorsement]

[Experience Refund Endorsement]

[Gapless Renewal Endorsement]

[No New Special Risk Limitations and Rate Cap Endorsement]

[Plan Mirroring Endorsement]

[Referenced Based Pricing Endorsement]

[Renewal Endorsement]

[Retained Corridor Endorsement]

[Specific Advanced Funding Endorsement]

[Specific Terminal Liability Endorsement]

[Transplant Vendor Endorsement]

APPLICANT STATEMENTS

The undersigned is an authorized representative of the Applicant and represents to the best of his knowledge and belief that the statements and disclosures set forth herein are true and complete and include all material information. Further, the undersigned understands that any Policy issued based on this Application is done so in reliance upon the statements, disclosures, and representations made herein and are made part of this Application.

The Applicant agrees that if the information supplied on this Application changes materially between the date of this Application and prior to the inception date of the policy, the Applicant will immediately notify the Company of the changes. It is understood that as a result, the Company may, upon review of such changes, withdraw or modify any outstanding quote, terms, or proposal.

The receipt by the Company of premium with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this Application, its sole obligation shall be to refund such premium to the undersigned.

The undersigned has read this Application for a Stop Loss Insurance Policy and understands that no insurance coverage is in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant _____

Signature of Authorized Representative: _____

Print Name: _____

Title: _____

Date: _____

AGENT/BROKER INFORMATION

Print Full Legal Name of Individual Agent or Broker _____
First *Middle* *Last*

Address _____
Street Address *City* *State* *ZIP*

Telephone No. ( ) _____ E-mail Address: _____

Resident State: _____ License Number: _____

Signature of Agent or Broker: _____ Date: _____

FRAUD WARNING NOTICE: Any person who knowingly and with intent to defraud any insurance company or another person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime and may subject the person to criminal and civil penalties.

The laws of several states require the following statements to appear on the application form. These statements apply only to residents of the noted states.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form or other explanatory words of similar meaning. The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable for insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or

knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. The absence of such a statement shall not constitute a defense in any prosecution.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The lack of such a statement does not constitute a defense in any prosecution for a fraudulent insurance act.

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.