USHL US Health and Life
US HEALTH AND LIFE INSURANCE COMPANY

SafeGuard

Employer Disclosure Form and Instructions for Completion

HIPAA Privacy permits the release **of Protected Health Information (PHI) for the purpose of evaluating and** accepting risk associated with the Plan Sponsor as a part of **"health care operations".** US Health and Life Insurance Company 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.

US Health and Life Insurance Company will rely upon the information provided on the attached disclosure statement, which will become part of the Application for excess loss coverage. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known, or which should have been known, as of the date of this disclosure by making a thorough review of all applicable records in their possession or in the possession of a service provider such as a Third Party Administrator. Such records shall include, but are not limited to, historical claims reports, disability records, and information from administrators, insurers, utilization management companies, managed care companies, pharmacy benefit management companies and any Agent/Broker of the Plan Sponsor. The attached Disclosure Form must be completed and signed by the appropriate parties no more than thirty (30) days prior to the proposed Effective Date of excess loss coverage unless otherwise agreed to by US Health and Life Insurance Company and received by US Health and Life Insurance Company within five (5) days of completion.

Upon receipt of the completed Disclosure Form, US Health and Life Insurance Company will assess all data, new and previously reported, and if information provided is complete, will inform the producer in writing when accepted or of any necessary changes to the rates, factors or terms of coverage. If information provided is incomplete, US Health and Life Insurance Company reserves the right to request complete information before proceeding. US Health and Life Insurance Company reserves the right to rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

When completing the Disclosure Form, remember that Covered Persons include those **on short or long-term disability, COBRA, FMLA, a leave of absence, extension of benefits, sick time, vacation time** or **retirees** covered under the plan and for whom coverage is requested in the quote. Please include anyone who recently lost coverage under the plan and is eligible for an extension of **coverage under COBRA or** a **plan provision allowing for continued coverage under the plan even if that extension has** not been elected.

It also includes anyone who previously reached a plan lifetime or annual maximum and is eligible for reinstatement under the plan under **federal law.**

Employer Disclosure Form

THIS DISCLOSURE FORM INCLUDES THE DISCLOSURE FORMS OF THE INDIVIDUAL EMPLOYEES AS ATTACHMENTS.

The following questions pertain to medical expenses of persons covered by the employee benefit plan ("Plan"). If the answer to any of the following questions is yes, provide complete details on page 3 of this form for each individual covered person and, if needed, attach supplemental reports (be sure to note the names and dates of supplemental reports provided on the Disclosure Form). This information will be treated as confidential by US Health and Life Insurance Company.

1.	Is(Are) there any Covered Person(s) who are currently disabled, confined to a Medical Facility, confined to home or elsewhere; in Case Management, in Care Management, in Disease Management or who have been pre-certified or pre-authorized for medical care within the last three months ?	❑ Yes	❑ No
2.	Has(Have) any Covered Person(s) received medical services during the current plan year the cost of which exceeds $50,000?	❑ Yes	❑ No
3.	Has(Have) any Covered Person(s) been identified as a candidate(s) for Case/Care Management and/or as having the potential to exceed $50,000 during the policy period?	❑ Yes	❑ No
4.	During the current plan year, has(have) any Covered Person(s) been diagnosed with or treated for a condition contained in the attached list?	❑ Yes	❑ No
5.	Has(Have) any Covered Person(s) been evaluated for, accepted into or listed at a transplant program?	❑ Yes	❑ No
6.	Has(Have) any current or former Covered Person(s) met the plan's maximum in the current plan year or any prior plan year?	❑ Yes	❑ No
7.	If the answer to question 6 is “yes”, have you offered reinstatement into the plan?	❑ Yes	❑ No
8.	Has(Have) any Covered Person(s) accumulated more than $500,000 of claims while covered under the plan?	❑ Yes	❑ No

If the Plan Sponsor fails to disclose any person known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then US Health and Life Insurance Company will re-evaluate the proposed coverage and rates and any Covered Person(s) not disclosed will be individually underwritten retroactively to the proposed effective date. US Health and Life Insurance Company reserves the right to terminate coverage for such person or limit such person's coverage under the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or change the terms of the Aggregate coverage quoted.

Plan Sponsor: _____ Effective Date: _____

Are there any risks to report which meet the disclosure criteria on page two? Yes ❑ No ❑

Name	DOB	SEX	(A)ctive (C)OBRA (R)etiree (T)ermed	Term Date or COBRA Status Pending (Y/N)	Prognosis Condition Code * (1 - 6)

* Prognosis Condition Codes: The condition listed on the treatment plan for the next 2 months is anticipated to be: (1) None/Stable (2) Limited/Claims expected to decline (3) Ongoing/Expect similar claims (4) Extensive/Expect claims to increase (5) Hospice (6) None/Expired

The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic claimants in accordance with the instructions attached to this Disclosure Form and that it is the result of a diligent search in accordance with those instructions.

The Plan Sponsor recognizes that failure to disclose any Covered Person known to fall into one of the categories set forth in the instructions attached to this form, either intentionally or because a thorough review of all records was not conducted, then the coverage proposed may be re-evaluated and such person not disclosed may be individually underwritten retroactively to the effective date.

US Health and Life Insurance Company reserves the right to terminate or limit the Covered Person's participation in the Policy, change or modify the billed amount or adjust the terms of the Aggregate coverage quoted.

Are supplemental reports being provided to meet the disclosure criteria? Yes ❑ No ❑
List the name and date of the reports provided:

_____

Plan Sponsor/Administrator:	Agent/Broker:
Signature:	Signature:
Name:	Name:
Title	Title
Date:	Date:

DISCLOSURE REFERENCE TOOL

INDICATIONS OF POTENTIALLY COMPLEX MEDICAL CONDITIONS

This listing suggests conditions which may indicate potentially complex medical conditions. Its purpose is to provide a tool to help identify conditions which should be considered for disclosure purposes. It is not intended to be used as an all inclusive disclosure listing.

❑ **I have reviewed the Disclosure Reference Tool**

AIDS	**Malignant Neoplasm**
Human Immunodeficiency Virus	
Kaposi's Sarcoma	**Malignant Neoplasm of Lymphatic & Hemopoietic Tissue**
Pneumocystis Carinii Pneumonia	Leukemia: Monocytic; Other; Unspec Cell Type
Primary Coccidioidomycosis (Pulm)	Hodgkin's Disease
Toxoplasmosis	Lymphoid Leukemia
	Lymphosarcoma and Other
Cardiac and Pulmonary Disease/Disorders	Multiple Myeloma
Aortic Aneurysm	Myeloid Leukemia
Cardiac Arrest	
Cardiomyopathy	**Miscellaneous Conditions**
Cardiac Complications	Alpha-1-Antitrypsin Deficiency
Cerebrovascular Disease - Acute	Chronic Hepatitis
Cerebrovascular Disease	Crohn's Disease
Chronic Airway Obstruction	Diabetes Mellitus Complications
Cystic Fibrosis	Gaucher's Disease / Lyosomal / Storage Disorders
Heart Failure	Hemophilia
Ischemic Heart Disease	Hepatitis
Post Inflammatory Pulm. Fibrosis	Hyperbaric Oxygen
Primary Pulmonary Hypertension	Immune Deficiencies and Autoimmune Disorders
Respiratory Arrest/Failure	Lipidoses (Gaucher's and Fabry Disease)
	Morbid Obesity
Diseases of Blood	w/BMI > 25
Agranulocytosis	Neurofibromatosis
Aplastic Anemia (Unspecified)	Pancreatitis – Chronic
Aplastic Anemia (Constitutional)	Peritoneal dialysis
Coagulation Defects	Primary Pulmonary Hypertension
Myelodysplastic Syndrome	Systemic Lupus Erythematosus
Thalassemia	Tracheostomy
	Tuberculosis
High Risk Pregnancy, Neonate, Pediatric	
Birth Trauma	**Multiple Trauma**
Bronchopulmonary Dysplasia	Burns (over 20% of total body surface)
Cardiac Complication	Closed Head Injury
Fetal Anomaly affecting Maternal Mgt.	Coma
Congenital Anomaly	Complications of Trauma
Disorders related to Low Birth Weight	Multiple Trauma
Disorders related to Short Gestation	Spinal Cord Injury
Intrauterine Hypoxia & Birth Asphyxia	
Multiple Gestation	**Transplantation, Failure & Complications**
Premature Rupture of Membranes	Transplantation
Respiratory Distress Syndrome	Complication of Transplanted Organs
Respiratory Syncytial Virus (RSV)	Organ Rejection
Supervision of High Risk Pregnancy	Renal Failure
	Liver Failure
Neuromuscular Disorders	
Cerebral Palsy	
Lou Gehrig's Disease (ALS)	
Guillian-Barre Syndrome	
Multiple Sclerosis	
Muscular Dystrophies & Other Myopathies	