ROCKPORT BENEFITS

DISCLOSURE for ROCKPORT BENEFITS

Part A

INFORMATIONAL USE

The information provided on the attached disclosure supplement form, will become part of the Application for Excess Loss Insurance. The form's objective is to allow Rockport Benefits to take underwriting action on all known individuals in the categories listed in Part B. The Proposed Policyholder is inherently responsible, either directly or through its designated agent or representative, to report accurately, all claims known as of the date of disclosure completion and corresponding Application signature. This process entails a thorough review of all applicable records, including historical claim reports, disability records, payroll records, current information from administrators, insurers, utilization management companies, managed care companies and any Agent/Broker of the Plan Sponsor. In good faith, Rockport Benefits will accept the liability for any truly unknown claimants. Unless otherwise agreed upon, the attached disclosure form must be completed by the applicable parties no earlier than 15 days before and no later than 15 days after the proposed Effective Date of an Excess Loss Insurance policy issued as a result of this application.

Upon receipt of the completed application and supplement, Rockport Benefits will analyze all data and will inform the Proposed Policyholder and his respective agent or representative in writing of any changes to the rates, factors or terms of coverage from those initially proposed. Rockport Benefits reserves the right to modify the terms of or entirely retract any proposal issued before we have received and reviewed all information supplied within this Application and disclosure supplement.

INSTRUCTIONS

When completing the disclosure supplement, please include any individuals insured under the Plan who are continuing coverage under COBRA, FMLA, are receiving short/long-term disability benefits, or leave of absence, extension of benefits, sick time, vacation time or who are retirees covered under the Plan.

Part B must reflect all individuals insured under the Plan who are known to meet any of the following criteria:

- ◊ Those currently confined to a hospital or other medical facility, are disabled or have been pre-certified for confinement and/or disability within the last 90 days.
- ◊ All those who have received medical services during the past 12 months, the cost of which exceeds the lesser of 50% of the lowest Specific Deductible requested and {$25,000} and for which the bills have been received by the Claims Administrator and entered into their claims system.
- ◊ Any individual(s) identified as a candidate for Case Management and/or as having the potential to exceed the lesser of 50% of the lowest Specific Deductible requested and {$25,000} during the policy period.
- ◊ Those who have been diagnosed within the past 12 months with any of the conditions on the Rockport Benefits, LLC Potential Catastrophic Loss List Requiring Notification form. This applies to any individual named in the Special Limitations section of Your Application and Policy Schedule submitted to us, or including but not limited to premature birth, cancer, organ transplant, and those requiring infusion therapies or medical devices and implants; and have also received services costing the lesser of {$5,000} and {20%} of the lowest Specific Deductible requested, during the same period.
- ◊ Any individual with expected RX claims equal to or greater than $5,000 per month.
- ◊ Any individual(s)currently eligible under Your Plan but formerly ineligible because they had reached any applicable Lifetime or Annual Maximum Benefit Limits.
- ◊ Any individual(s) with claims that have been incurred but not paid solely because they have been referred to and are pending a decision from an Independent Review Organization.

ROCKPORT BENEFITS

APPLICATION FOR GROUP EXCESS LOSS INSURANCE
Disclosure Supplement

The information contained herein shall be deemed part of the Application for Excess of Loss Coverage and considered endorsed by the Application signatures provided.

Part B

Plan Insured/Claimant	DOB	Sex	EE, Sp or Ch	(A)ctive, (C)OBRA, (R)etiree, or (T)ermed	Term Date	Diagnosis	Prognosis	Most Recent Date of Service	Expenses Incurred During Last 12 months

If the Proposed Policyholder fails to disclose any person insured under the Plan who is known to meet any of the criteria specified in the Instructions section of this form, either intentionally or because a thorough review of all records was not conducted, Rockport Benefits will have no liability for reimbursement of expenses incurred for that person.

The Proposed Policyholder named below represents that the above list accurately and completely discloses all persons insured under the Plan who meet any of the criteria in the Instructions section of this form, and that it is the result of a diligent search in accordance with those instructions.

☐ Please check this box if there are no claimants who meet the disclosure criteria above to report.

P R I V A C Y P L E D G E: State and Federal Privacy rules permit the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Proposed Policyholder's Plan as part of Health Care Operations. Rockport Benefits shall use information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI gathered to any other person or for any other purpose.

G R O U P N A M E: _____

D A T E: _____