All Savers Insurance Company
A Stock Company
PO Box 19032, Green Bay, WI 54307-9032
Phone: 1-800-232-5432

Application For Excess Loss Insurance

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by All Savers Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant:		
Address (street, city, state, and ZIP):		
Key Contact:	Telephone:	Tax ID:

Applicant is a: ❑ Corporation ❑ Labor Union ❑ Partnership ❑ Association ❑ Proprietorship ❑ Other: _____

Nature of Business of the Group to be Insured: _____ Requested Effective Date: _____

Total number of eligible persons: Employees: _____

Are retirees covered: ❑ Yes ☒ No

Affiliates or Subsidiaries: _____ Addresses of Affiliates or Subsidiaries: _____

_____ _____

Full Name of Administrator: United HealthCare Services, Inc.

Address: PO Box 19032, Green Bay, WI 54307-9032

Key Contact: Jenny Matz Telephone: 800-232-5432

Agent or Broker: _____

Tax ID: _____

Address: _____

SPECIFIC EXCESS LOSS INSURANCE: ☒ YES ❑ NO

Incurred Benefit Period: From _____ through _____

Paid Benefit Period: From _____ through _____

Specific Deductible per Covered Person: $15,000.00
Specific Percentage Reimbursable: 100%
Maximum Specific Benefit per Covered Person: Unlimited

Covered Expenses Under Specific Excess Loss: Medical

AGGREGATE EXCESS LOSS INSURANCE: ☒ YES ❑ NO

Incurred Benefit Period: From _____ through _____

Paid Benefit Period: From _____ through _____

Covered Expenses under Aggregate Excess Loss Coverage: ☒ Medical
☒ Stand-Alone Prescription Drug Program

Aggregate Percentage Reimbursable: 100%

Maximum Aggregate Benefit: Unlimited

Minimum Annual Aggregate Deductible: N/A

Runout Deductible: 125%, multiplied by the incurred but unreported Covered Expenses, determined as of the first day of the 4th month immediately following the last day of the Incurred Benefit Period.

Aggregate Accommodation Endorsement: ☒ YES ❑ NO

It is understood and agreed by the undersigned that:

a. The statements, declarations, and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.

b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 30 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 30 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

c. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.

d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.

e. The receipt by the Company of the first month's premium and deposit of any check drawn in connection 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 sum to the undersigned.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ Title: _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

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FRAUD WARNING NOTICES: *(Please review notice that applies in your state)*

For applicants in Alabama, Arkansas, Louisiana, New Mexico, and 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.

For applicants in 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 from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for 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 application.

For applicants in Florida:

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.

For applicants in Kentucky, New Mexico, Ohio, and 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.

For applicants in Maine, Tennessee, and Virginia:

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 a denial of insurance benefits.

For applicants in 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.

For applicants in 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.

For applicants in all other states:

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 a denial of insurance benefits.

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