SPECIFIC AND AGGREGATE INSURANCE DISCLOSURE FORM

East Coast Underwriters, LLC

P.O. Box 2468
Spartanburg, SC 29304
864-542-1565 fax 864-542-1598

Group Name:
Effective Date:

A) In the past 12 months, has any one person covered under your Employee Benefit Plan's incurred claims in excess of $_____ (50% of the Specific Deductible or $10,000)?
B) Are you aware of any person with the potential to exceed $_____ (or 50% of the Specific Deductible) for the next 12 months?
C) Do you have any employees/dependents who are presently disabled or on COBRA?
D) If you answered "Yes" to A, B, or C, please give details below.

QUESTION	NAME	Employee, Retiree, COBRA or Dep.	DOB	At Work, Disabled, Hosp. Confined	DIAGNOSIS AND PROGNOSIS	DESCRIBE CURRENT TREATMENT	PAID TO DATE

This information will be treated as confidential by East Coast Underwriters

The Plan Sponsor named below, through its authorized person, hereby warrants and represents that the above information is true, complete, and accurate to the best of his/her knowledge, and that nothing has been knowingly or intentionally omitted. The Plan Sponsor further acknowledges, understands and agrees that this information may be used by ECU on behalf of the insurance carriers in evaluating and determining the acceptability of the risk.
The undersigned has contacted their Utilization Review/Large Case Management Company, Claims Administrator, and Human Resources Manager to verify the above data.

The Plan Sponsor acknowledges that excess loss insurance coverage is available to individuals who are disabled and not actively at work or are unable to perform the same dut of an individual of the same age and sex on the effective date of coverage only if such individuals are disclosed as such herein. This Disclosure Form will be made part of the Ma Application and Insurance Contract.

PLAN SPONSOR _____ ADDRESS _____
AUTHORIZED PERSON _____
Title_____ Date of Disclosure _____