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**STOP LOSS DISCLOSURE FORM AND INSTRUCTIONS FOR COMPLETING**

**HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of “health care operations”.**  East Coast Underwriters, LLC and the Carrier 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.

**East Coast Underwriters and the Carrier will rely upon the information provided on the attached disclosure form, which will become part of the application for stop loss coverage.** The purpose of the form is to allow East Coast Underwriters to take underwriting action on all known individuals in the categories listed below. 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 though 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 not be limited to, historical claim reports, disability records, payroll records and current information from administrators, insurers, utilization management companies, managed care companies, pharmacy benefit management companies and any Agent/Broker of the Plan Sponsor.

In exchange, East Coast Underwriters and the Carrier will accept the liability for any truly unknown claimants. **The attached disclosure form must be completed and signed by the appropriate parties no earlier than thirty (30) days prior to the proposed Effective Date of stop loss coverage unless otherwise agreed to in writing** by East Coast Underwriters and the Carrier and received by East Coast Underwriters within five (5) days of completion.

Upon receipt of the completed disclosure, East Coast Underwriters and the Carrier will assess all data, new and previously reported, and if the 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 the information provided is incomplete, the East Coast Underwriters and the Carrier reserves the right to request complete information before proceeding. We reserve the right to request Individual Medical Questionnaires at any time. East Coast Underwriters and the Carrier reserves the right to revise or rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

**Additionally, by signing the below I attest that the following information has been provided to East Coast Underwriters: all available claims and large claims data in accordance with what is typically released by the Carrier in the group and/or Carrier’s state of business, renewal rates with headcounts and a current list of the number of employees covered under the current plan.**

**PLAN SPONSOR**: SIGNATURE/NAME **DATE SIGNED**: Click to enter date **EFFECTIVE DATE**: Click to enter a date. **INITIALS**: XX

**STOP LOSS DISCLOSURE FORM**

The following questions pertain to medical expenses of persons covered by the employee benefit plan (“Plan”). When completing the form, remember that “Covered Persons” include those on short or long-term disability, COBRA, FMLA, leave of absence, extension of benefits, sick time, vacation time, anyone in their waiting period 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 as not been elected.

If the answer to any of the following questions is ‘Yes’, provide complete details on page three 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 with the disclosure statement). This information will be treated as confidential by East Coast Underwriters and the Carrier.

1. **Individuals who are currently confined to a medical facility, at home or elsewhere, in Case Management, in Disease Management or have been pre-certified in the last 3 months.**
2. **Individuals that have received medical or prescription drug services during the current plan year the cost of which exceeds the lesser of 50% of the lowest specific retention amount quoted or $50,000.**
3. **Any individuals that have been identified as candidates for Case Management and/or as having the potential to exceed lesser of 50% of the lowest specific retention amount quoted or $50,000.**
4. **Any Covered Person(s) that have been diagnosed with or treated for a condition represented by any of the ICD-10 codes contained in the attached list**
5. **Individuals that have been evaluated for or accepted into a transplant program.**
6. **Any Covered Person(s) currently, or in the last 180 days, on Workman's Compensation, Disability, COBRA, In COBRA Election period, FMLA, Medical leave, Retiree or Hospitalized?**

**If the Plan Sponsor fails to disclose any Plan Participant known to fall into one of the above categories, either intentionally or because a thorough review of all records was not conducted, then the coverage proposed may be re-evaluated and any Covered Person(s) not disclosed may be individually underwritten retroactively to the effective date. We reserve the right to terminate or limit the covered Person’s participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific or Aggregate coverage quoted.**

**PLAN SPONSOR**: SIGNATURE/NAME **DATE SIGNED**: Click to enter date **EFFECTIVE DATE**: Click to enter a date. **INITIALS**: XX

**EMPLOYER STOP LOSS DISCLOSURE STATEMENT**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name** | **DOB** | **Sex** | **E/SP/CH** | **(A)ctive, (C)obra, (R)etiree, (T)ermed** | **Plan is (P)rimary or (2)ary** | **Term date?****COBRA status pending? (Y/N)** | **Diagnosis** | **Most recent date of service** | **Prog Cond****Code (1-6)\*** | **In CM?\*\***  | **Paid/****pended losses this plan year** | **Paid/ Pended Losses Since Coverage Began** |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |
| Name | DOB | MF | E/SP/CH | A/C/R/T | P/2 | Term dateY/N | Diagnosis | DOS | 1-6 | Y/N | $$$ | $$$ |

\* Condition Codes: Related to the condition listed the treatment plan for the next 12 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.

\*\*if in CM, please attach reports.

\*\*\*If there are more claimants than available spaces, please provide on separate sheet

**The Plan Sponsor named below represents that the above list accurately discloses all potentially catastrophic claimants in accordance with the instructions attached to this form and that it is the result of a diligent search in accordance with those instructions. The Plan Sponsor recognizes that if the Plan Sponsor fails 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 any Covered Person(s) not disclosed may be individually underwritten retroactively to the effective date. We reserve the right to terminate or limit the covered Person’s participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific or Aggregate coverage quoted. If supplemental reports are being provided to meet the disclosure criteria, please check the box below and list the name and date of the reports provided:**

[ ] If box is checked, please provide reports and list the name and date of the reports provided here

|  |  |  |  |
| --- | --- | --- | --- |
|  | **PLAN SPONSOR (required)** | **CLAIMS ADMINISTRATOR\*** | **BROKER/AGENT (required)** |
| **COMPANY NAME** | PLAN SPONSOR NAME | TPA NAME | AGENCY NAME |
| **SIGNATURE** |  |  |  |
| **NAME** | SIGNERS NAME | SIGNERS NAME | SIGNERS NAME |
| **TITLE** | TITLE | TITLE | TITLE |
| **DATE** | DATE | DATE | DATE |

*\*If changing TPA’s, do not need to complete Claims Admin section*

**INDICATIONS OF POTENTIALLY COMPLEX MEDICAL CONDITIONS BY ICD10**

**DISCLOSURE REFERENCE TOOL**

The following list suggests conditions and related ICD10(s) which may indicate potentially complex medical conditions. Its purpose is to provide a tool to help our clients identify cases which should be considered for disclosure purposes. It is not intended to be used as an all inclusive disclosure listing. Please refer to the disclosure statement terms for specific requirements to assure complete disclosure.

|  |  |
| --- | --- |
| **AIDS** | **ICD10(s)** |
| Human Immunodeficiency Virus | B20 |
| Kaposi's Sarcoma | C46x |
| Pneumocystis Carinii Pneumonia | B59 |
| Primary Coccidioidomycosis (pulm) | B38.0 |
| Toxoplasmosis | B58x |
| **Cardiac and Pulmonary Disease/Disorders** |
| Aortic Aneurysm | I71x |
| Cardiac Arrest | I46.9 |
| Cardiomyopathy | I42x |
| Cardiac Complications | I97.10, I97.790, I97.88-.89 |
| Cerebrovascular Disease-Acute | I67.89 |
| Cerebrovascular Disease | I60.9, I61.9, I62x, I66x, I63.40 |
| Chronic Airway Obstruction | J44.9 |
| COVID-19 | U07.1, U07.0 |
| Cystic Fibrosis | E84x |
| Heart Failure | E50x |
| Ischemic Heart Disease | I50x |
| Post Infammatory Pulm. Fibrosis | I21x, I24.1, I20.0 |
| Primary Pulmonary Hypertension | I27.0 |
| Respiratory Arrest/Failure | R09.2, J96x |
| Vaping-related Disorders | U07.0 |
| **Disease of Blood** |
| Agranulocytosis | D70x |
| Aplastic Anemia (Unspecified) | D60x, D61.9 |
| Aplastic Anemia (Constitutional) | D61x |
| Coagulation Defects | D66.0-68.99 |
| Myelodysplastic Syndrome | D47x |
| Thalassemia | D56x |
| Sickle Cell Anemia | D57x |

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| **High Risk Pregnancy, Neonate, Pediatric** | **ICD10(s)** |
| Birth Trauma | P10-P15.99, P52x |
| Bronchopulmonary Dysplasia | P27x |
| Cardiac Complications | 074.2-O89.1 |
| Fetal Anomaly affecting Maternal Mgt. | O350XX0-O35.9XX0 |
| Congenital Anomaly | Q00.0-Q89.99 |
| Disorders related to Low Birth Weight | P07.01-P07.30 |
| Disorders related to Short Gestation | P07.20-P07.37 |
| Intrauterine Hypoxia & Birth Asphyxia | P84 |
| Multiple Gestation | O03.009-O30.93 |
| Premature Rupture of Membranes | O42.011-O42.013 |
| Respiratory Distress Syndrome | P22.0 |
| Respiratory Syncytial Virus (RSV) | B97.4 |
| Supervision of High Risk Pregnancy | O09.00-O09.93 |
| **Chronic Psychiatric Disorders** |
| Schizophrenia | F20.89-F20.99 |
| Mood Disorders | F30.10-F34.8 |
| Alcohol Dependence | F10.229-F10.21 |
| Drug Dependence | F11.20-F19.21 |
| Anorexia Nervosa | F50.00 |
| **Neuromuscular Disorders** |
| Cerebral Palsy | G80.0-G80.99 |
| Lou Gehrig's Disease (ALS) | G12.21 |
| Guillian-Barre Syndrome | G61.0 |
| Multiple Sclerosis | G35 |
| Muscular Dystrophies & Other Myopathies | G71.2-G72.9 |
| **Cancer (Malignant Neoplasm)** | C00.0-C80.2 |
| **Malignant Neoplasm of Lymphatic & Hemopoietic Tissue** |
| Leukemia: Monocytic: Other Unsp Cell Type | C93.00-C95.92 |
| Hodgkin's Disease | C81.70-C81.98 |
| Lymphoid Leukemia | C91.00-C91.92 |
| Lymphosarcoma and Other | C83.30-C96.Z |
| Multiple Myeloma | C90.00-C90.32 |
| Myeloid Leukemia | C92.00-C92.92 |

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| --- | --- |
| **Miscellaneous Conditions** | **ICD10(s)** |
| Alpha-1-Antitrypsin Deficiency | E88.01 |
| Amyloidosis | E85.1-E85.99 |
| Crohn's Disease | K50x |
| Diabetes Mellitus Complications | E10.65-E11.51, R09.89 |
| Hepatitis | B15.0-B19.9 |
| Immune Deficiencies | D80.1-D89.9 |
| Lipidoses (Gaucher's and Fabry Disease) | E75.21-E77.1 |
| Morbid Obesity | E66x |
|  w/BMI > 25 | Z68.25-Z68.45 |
| Neurofibromatosis | Q85.00-Q85.02 |
| Pancreatitis - Chronic | K86.1 |
| Systemic Lupus Erythematosus | M32.10 |
| Tuberculosis | A15.7-A19.9 |
| Joint Disorders | M25.40-M25.99 |
| Spinal Disorders | M43.8x9, M53.9 |
| Gender Reassignment | F64-F64.99 |
| **Multiple Trauma** |
| Burns (over 20% of total body surface) | T30.0-T31.20 |
| Closed Head Injury | S02.91XA-S06.9X0A |
| Coma | R40.20 |
| Complications of Trauma | T79.0XXA-T79.8XXA |
| Multiple Trauma | T07 |
| Spinal Cord Injury | S12.000A, S14.109A |
| **Transplantation, Failure & Complications** |
| Transplantation | Z94x, Z51.89 |
| Complication of Transplanted Organs/Organ Rejection | T86.890-T86.90 |
| Renal Failure | N17.0-N19 |
| Liver Failure | K72.10-K72.90 |

Note: “x” denotes the entire range of subset numbers (.0-.99)

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