EMPLOYER BENEFIT UNDERWRITERS, INC.

100 LaCosta Lane, Suite 120, Daytona Beach, FL 32114
Phone (386) 274-2600 * Fax (386) 274-4111

PLAN SPONSOR DISCLOSURE STATEMENT

Employer Benefit Underwriters, Inc. requires a Plan Sponsor Disclosure Statement on all eligible Employees, Dependents, Retirees, and COBRA Participants covered under the proposed plan on or after the proposed effective date of insurance who may be disabled by an illness or injury and/or who fall into a category of high risk (please use our criteria in the Disclosure Contingency section below). It is very important that you review all available reports (sick leave, disability, pended or subrogated, pre-certification, utilization review and/or case management reports, etc.). **Failure to disclose all known individuals who are high risk will result in reduced or denied coverage.**

The Specific Stop-Loss Agreement contains a provision excluding coverage for employees who are disabled and not actively at work, or dependents who are ill and/or hospitalized on the Policy Effective Date. However, as an underwriting consideration, the Insurer(s) MAY agree to waive this provision for such persons, if the Plan Sponsor discloses the following pertinent details regarding all such known individuals as of a date not exceeding 15 days prior to the proposed effective date. (Choose (1) to denote these persons).

Further, the Plan Sponsor is required to disclose the same information for covered individuals whose benefits under the Plan have exceeded 50% of the Specific during the 12 month period immediately preceding the Policy Effective Date, or have a condition that may exceed 50% of the Specific. (Choose (2) to denote these persons).

Please complete by either filling in the table below, by indicating NONE, or by indicating SEE ATTACHED - blank forms will NOT be accepted. Feel free to continue on a separate sheet as needed; however, any attached pages should be dated and initialed by the same parties who sign below (**see date requirements below).

Name:	Date of Birth:
Is person: Employee [ ] or Dependent [ ]?	Date of Disability:
Date expected to return to work:	Disclosure Category: 1 [ ] or 2 [ ]
Diagnosis or Nature of Disability:	(See paragraphs above for category descriptions)
Current Health Status:	
Add'l Claims Estimate: $	Benefits paid (2 months): $
Name:	Date of Birth:
Is person: Employee [ ] or Dependent [ ]?	Date of Disability:
Date expected to return to work:	Disclosure Category: 1 [ ] or 2 [ ]
Diagnosis or Nature of Disability:	(See paragraphs above for category descriptions)
Current Health Status:	
Add'l Claims Estimate: $	Benefits paid (2 months): $
Name:	Date of Birth:
Is person: Employee [ ] or Dependent [ ]?	Date of Disability:
Date expected to return to work:	Disclosure Category: 1 [ ] or 2 [ ]
Diagnosis or Nature of Disability:	(See paragraphs above for category descriptions)
Current Health Status:	
Add'l Claims Estimate: $	Benefits paid (2 months): $

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Disclosure Contingency (Criteria for evaluating high risk):

An Employee is a high risk if he/she is:

- Not working full-time, or receiving reduced earnings, due to an illness or injury; or
- Not able to work at his/her normal place of employment due to illness or injury; or
- Not able to perform his/her normal job duties due to illness or injury; or
- No longer able to work the minimum number of hours required by the plan, due to illness or injury; or
- Receiving Social Security Disability Income or another type of disability income; or
- Identified as a high-risk pregnancy; or
- Being evaluated, or has been evaluated, for an organ, tissue, stem cell, or bone marrow transplant; or
- Has or had a renal disease with or without dialysis
- Expected to, or already has incurred claims that 50% of the Specific Deductible during the 12 month period immediately preceding the Policy Effective Date.

A Retiree, Dependent or COBRA participant is a high risk if he/she is:

- Confined to hospital or home, or disabled due to illness or injury; or
- Receiving Social Security Disability Income or another type of disability income; or
- Unable to perform the normal activities of a person of the same age and gender; or
- Being evaluated, or has been evaluated, for an organ, tissue, stem cell, or bone marrow transplant; or
- Identified as a high-risk pregnancy; or
- Has or had a renal disease with or without dialysis
- Expected to, or already has incurred claims that 50% of the Specific Deductible during the 12 month period immediately preceding the Policy Effective Date.

The Plan Sponsor named below, through its Authorized Person, hereby warrants and represents that the above list, and additional (   ) pages attached, is true, complete and accurate to the best of his/her knowledge and belief, and that nothing has been knowingly or intentionally omitted. **The Plan Sponsor understands that any reports attached to this Disclosure Statement must be dated within 5 business days of the date this Disclosure Statement is signed. The Plan Sponsor further acknowledges, understands and agrees that this information may be used by the Insurer(s) in evaluating and determining the acceptability of the Plan Sponsor's risk and that no coverage shall be provided for such persons unless specifically agreed to in writing by the Insurer(s). **This information shall be treated confidentially.**

Representative	Print Name of Authorized Person	Signature of Authorized Person	Date
Plan Sponsor			
Administrator			
Insurer Underwriter			