



Disclosure Statement

Revised 10/2011

Please read carefully

General: The information presented in this attached disclosure statement form (herein referred to as the disclosure, disclosure form, disclosure statement, or form) will be relied upon by Bardon Insurance Group, a duly appointed managing general underwriter for the issuing carrier (herein referred to as Bardon, we, our or us), as part of the underwriting process for the group. The disclosure will become part of the application for stop loss coverage and as such will ultimately become part of the treaty (policy). We reserve the right to require / pursue additional information (medical or otherwise) based on the information provided. Coverage would then become contingent upon the receipt, review and approval of that information by us. In addition, we reserve the right to change premium rates / factors, modify the terms of coverage, or withdraw the proposal in its entirety based upon a review of the information submitted during the disclosure process or acquired as a result thereof.

Failure to disclose a known individual / situation or severity thereof may lead to the rescission of coverage or modification of the terms of coverage and / or premium. In that event, the action taken will be solely at our discretion.

Individuals to be disclosed:

1. Plan participants, including all dependents, (defined as anyone that has or may incur claims under the scope of the plan document) that are inpatient in a hospital or other medical facility as of the date on which the disclosure is signed.
2. Plan participants that have been pre-certified for an inpatient stay within the three months prior to the signature date.
3. Plan participants that have incurred claims during the current plan year that exceed the lesser of 50% of the specific deductible applied for or \$50,000.
4. Plan participants that have been diagnosed with or received treatment for a condition on the attached diagnoses list (including denied, suspended and pended claims), have otherwise been identified as a candidate for Case Management or have had claims denied that exceed the lesser of 50% of the specific deductible applied for or \$50,000.
5. Plan participants that as of the date the disclosure is signed are:
 - a. Not actively at work
 - b. On COBRA or are eligible for COBRA
 - c. Covered under a disabled or handicapped child extension provision
 - d. Known to be disabled or otherwise unable to engage in those activities for which an individual of the same age would ordinarily be expected to do.

Sources of Information: A diligent and thorough current review should be made by the plan sponsor or their duly appointed representative of all applicable records including but not limited to:

- current and past claim reports (including pended, suspending and denied claims)
- information from the current administrator or insurer
- information known to a managed care company (utilization management firm, large case management firm and / or provider network)
- employment records, disability records
- information known by the broker / agent

Information Required: The name of the individual or a unique identifier, the reason for the disclosure, scheduled or anticipated procedures medical / surgical treatments, scheduled or anticipated leaves of absence and other information as required and as applicable on the attached disclosure statement are the standards which will constitute full and fair disclosure. The plan sponsor / administrator may include their own reporting format in as much as the data supplied meets or exceeds these standards. Reference to an individual by name or claimant identifier only does not constitute disclosure.

Timing Issues: The information in the disclosure form must be accurate as of the date that the form is signed. The form may be signed no more than 60 days in advance of the proposed effective date and must be received by Bardon no more than 5 days from that date. If the disclosure is signed greater than 30 days before the effective date, ½ of the first month's premium and a signed application must be received within 5 days of the date that Bardon provides written acceptance of disclosure. The remainder must be received prior to the effective date. If the disclosure is signed within 30 days of the effective date, a signed application must be submitted within 5 days of the date that Bardon provides written acceptance of disclosure. Should these conditions not be met, the disclosure is invalid.

Questions regarding disclosure: Should there be any question as to whether an individual should be disclosed or a question as to the information required for disclosure, **do not hesitate to contact us.**

Value of Disclosure: In exchange for this disclosure, Bardon on behalf of the issuing carrier will accept liability for claimants that are unknown in fact and will waive any actively at work or actively at life provisions for individuals disclosed as such.

NO COVERAGE IS BOUND UNTIL THE ALL REQUIRED DOCUMENTATION HAS BEEN RECEIVED AND APPROVED BY BARDON ON BEHALF OF THE ISSUING CARRIER. PLEASE REFER TO BARDON'S SOLD CASE DOCUMENTATION GUIDELINES FOR MORE INFORMATION. ALL INDIVIDUALS WHO HAVE PREVIOUSLY EXCEEDED THEIR LIFETIME MAXIMUM ARE EXCLUDED FROM COVERAGE UNTIL WE HAVE PROVIDED WRITTEN ACCEPTANCE.



Trigger Diagnosis List for Disclosure Statement

Infectious and Parasitic Diseases

| | |
|-------------|------------------------------------|
| 038 - 038.9 | Septicemia |
| 042 | Human immunodeficiency virus [HIV] |
| 070 - 070.9 | Hepatitis |

Neoplasms

| | |
|--------------|-------------------------------------|
| 140 - 208.91 | Cancers, Leukemias, Lymphomas, etc. |
|--------------|-------------------------------------|

Endocrine, Metiz 1. Plan participants, including all dependents, (defined as anyone that has or may incur claims under the scope of the plan document) that are i

| | |
|--------------|---|
| 250 - 250.93 | Diabetes |
| 277 - 277.09 | 3. Plan participants that have incurred claims during the current pla |

| | |
|--------------|---|
| 278 - 278.02 | 4. Plan participants that have been diagnosed with or received trea |
| 279 - 279.9 | Immune Disorders |

Diseases of Blood and Blood Forming Organs

| | |
|-------------|--|
| 282 - 282.9 | Anemias (includes Sickle Cell) |
| 284 - 284.9 | Aplastic Anemia |
| 286 - 286.9 | Coagulation defects |
| 287 - 287.9 | Purpura and other hemorrhagic conditions |
| 288 - 288.9 | Diseases of white blood cells |

Disorders of Nervous System and Sense Organs

| | |
|-------------|--|
| 330 - 330.9 | Cerebral degenerations usually manifest in childhood |
| 331 - 331.9 | Other cerebral degenerations |
| 332 - 332.1 | Parkinson's disease |
| 333.4 | Huntington's chorea |
| 335 - 335.9 | Anterior horn cell disease (incl ALS / Lou Gerhig's Disease) |
| 336 - 336.9 | Other diseases of spinal cord |
| 340 - 341.9 | Multiple Sclerosis and other dymylinating disorders |
| 343 - 343.9 | Cerebral Palsy |

| | |
|-------------|---|
| NO COVERAGE | Quadruplegia |
| 344.1 | Paraplegia |
| 348 - 348.9 | Other conditions of brain |
| 357 - 357.9 | Inflammatory and toxic neuropathy |
| 358 - 358.9 | Myasthenia Gravis and other myoneural disorders |
| 359 - 359.9 | Muscular dystrophies and other myopathies |

Disorders of the Circulatory System

| | |
|--------------|--|
| 391 - 398.99 | Rhematic heart and valvular disorders |
| 402 - 404.93 | Hypertensive heart and kidney disorders |
| 410 - 410.92 | Acute myocardial infarction |
| 411 - 417.9 | Ischemic heart, coronary atherosclerosis, etc. |
| 421 - 421.9 | Endocarditis |
| 424 - 424.99 | Valvular and other endocardial disorders |
| 425 - 425.9 | Cardiomyopathy |
| 426 - 427.9 | Cardiac conduction issues and dysrhythmias |
| 428 - 428.9 | Heart Failure |
| 429 - 429.9 | Ill - defined & complications of heart disease |
| 430 - 431 | Cerebral hemorrhage |
| 433 - 437.9 | Cerebrovascular issues |
| 440 - 447.9 | Other vascular issues |
| 456 - 456.21 | Esophageal Varices |

Disorders of the Respiratory System

| | |
|--------------|--------------------------------|
| 480 - 486 | Pneumonia |
| 490 - 496 | Obstructive pulmonary diseases |
| 515 | Pulmonary fibrosis |
| 518 - 518.89 | Other respiratory diseases |

Digestive Disorders

| | |
|--------------|------------------------------|
| 555 - 555.9 | Regional Enteritis (Crohn's) |
| 556 - 556.9 | Ulcerative Colitis |
| 557 - 557.9 | Intestinal vascular issues |
| 560 - 560.9 | Intestinal obstruction |
| 562 - 562.13 | Diverticulitis |

Digestive Disorders (continued)

| | |
|-------------|-----------------------------|
| 567 - 567.9 | Peritonitis |
| 570 - 573.9 | Liver disease / cirrhosis |
| 577 - 577.9 | Disorders of pancreas |
| 578 - 578.9 | Gastrointestinal Hemorrhage |

Genitourinary Disorders

| | |
|-------------|--|
| 580 - 580.9 | Glomerulonephritis |
| 588 | Disorders resulting from impaired renal function |
| 584 - 587 | Renal Failure |
| 592 | Calculus of Kidney and Ureter |

Pregnancy and Childbirth

| | |
|-----|-----------------|
| 630 | Hydatiform mole |
|-----|-----------------|

| | |
|----------------|--------------------------------------|
| 640 - 641.93 | Hemorrhage in pregnancy |
| 642 - 642.94 | Hypertensive issues during pregnancy |
| 644 - 644.21 | Early Labor |
| 648 - 648.04 | Gestational Diabetes |
| 651 - 651.93 | Multiple Gestation |
| 654.5 | Cervical Incompetence |
| 658.1 - 658.13 | Premature rupture of membranes |

Disorders of the Musculoskeletal and Connective Tissue

| | |
|--------------|--|
| 710 - 710.9 | Diffuse disease of connective tissue (Lupus, etc.) |
| 715 - 715.98 | Osteoarthritis |
| 721 - 721.91 | Spondylosis and allied disorders |
| 722 - 724.9 | Back and Spinal disorders |
| 730 - 730.99 | Osteomyelitis and periostitis |
| 737 - 737.9 | Curvature of Spine |

Congenital Disorders

| | |
|--------------|------------------------------------|
| 740 - 741.93 | Spina Bifida and similar anomalies |
| 742 - 742.9 | Anomalies of the nervous system |

| | |
|----------------|--|
| 745 - 747.9 | Congenital cardiac and circulatory issues |
| 748 - 748.9 | Congenital anomalies of respiratory system |
| 751 - 751.9 | Congenital anomalies of digestive system |
| 753.1 - 753.22 | Congenital renal anomalies |
| 759 - 759.9 | Other and unspecified congenital anomalies |

Perinatal Conditions

| | |
|--------------|---|
| 765 - 765.27 | Prematurity |
| 769 | Respiratory Distress in Newborn |
| 770 - 770.9 | Other respiratory conditions of fetus and newborn |

Symptoms and Signs

| | |
|----------------|---|
| 785 - 785.9 | Symptoms involving cardiac / respiratory system |
| 786.5 - 786.59 | Chest Pain |

Injury and Poisoning

| | |
|----------------|---|
| 800 - 804.99 | Fracture of skull |
| 805 - 806.9 | Fracture of vertebral column / spinal cord injury |
| 828 - 828.1 | Multiple Fractures |
| 853 - 854.19 | Intracranial Injury |
| 869 - 869.1 | Internal Injury |
| 887 - 887.7 | Traumatic amputation of arm and hand |
| 897 - 897.7 | Traumatic amputation of Leg |
| 941.3 - 941.59 | } Burns |
| 942.3 - 942.59 | |
| 943.3 - 943.59 | |
| 944.3 - 944.58 | |
| 945.3 - 945.59 | |
| 952 - 952.9 | Spinal cord injury |
| 996 - 997.09 | Complications |

"V" Codes

| | |
|-------------|------------------------------------|
| V23 - V23.9 | Supervision of high risk pregnancy |
| V42 - V58.9 | Transplants, Implants, etc. |

DISCLOSURE STATEMENT

Group Name:

| Name or Claimant Identifier | Date of Birth | Not Actively at Work? | Disabled? | COBRA / COBRA Eligible? | FMLA or Other Leave of Absence? | Date of Disability / COBRA | Diagnoses / Nature of Disability | Current Year Pending and Paid Claims | Other pertinent details (for example severity of condition, scheduled or anticipated medical / surgical treatments or leaves of absence) |
|-----------------------------|---------------|--------------------------|--------------------------|--------------------------|---------------------------------|----------------------------|----------------------------------|--------------------------------------|--|
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- Check if there are additional pages attached. If so, the number of additional pages is: _____
- Check if the above information is being supplied electronically. The file name's are: _____

The plan sponsor by their herein below appearing signature represents the above and / or any attached information to be the product of a prudent review as described in the previous pages and as such represents the above and / or any attached information to be a complete and truthful disclosure of all individuals in accordance with the attached instructions as of the date signed. In exchange for this disclosure, Bardon on behalf of the issuing carrier will accept liability for claimants that are unknown in fact and will waive any actively at work or actively at life provisions for individuals disclosed as such.

Plan Sponsor

Signature: _____
 Date: _____
 Name (printed): _____

Claims Administrator

Signature: _____
 Date: _____
 Name (printed): _____

WRITTEN ACCEPTANCE: _____

Title _____

Disclosure Addendum / Reaffirmation

Group Name:

The following is an addendum to the disclosure signed on __/__/____.

| Name or Claimant Identifier | Date of Birth | Not Actively _at Work? | Disabled? | COBRA / COBRA Eligible? | FMLA or Other Leave of Absence? | Date of Disability / COBRA | Diagnoses / Nature of Disability | Current Year Pending and Paid Claims | Other pertinent details (for example severity of condition, scheduled or anticipated medical / surgical treatments or leaves of absence) |
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OR

The disclosure as signed on __/__/____ remains complete with no changes.

The plan sponsor by their herein below appearing signature represents the above and / or any attached information to be the product of a prudent review as described in the previous pages and as such represents the above and / or any attached information to be a complete and truthful disclosure of all individuals in accordance with the attached instructions as of the date signed. In exchange for this disclosure, Bard on behalf of the issuing carrier will accept liability for claimants that are unknown in fact and will waive any actively at work or actively at life provisions for individuals disclosed as such.

Plan Sponsor

Signature: _____
 Date: _____
 Name (printed): _____
 Title: _____

Claims Administrator

Signature: _____
 Date: _____
 Name (printed): _____
 Title: _____