KAISER PERMANENTE INSURANCE COMPANY
One Kaiser Plaza
Oakland, California 94612
(Herein called the Company)

KAISER PERMANENTE®
Kaiser Permanente Insurance Company

APPLICATION AND DISCLOSURE STATEMENT FOR STOP LOSS INSURANCE

Complete this Stop Loss Application and Disclosure Statement in its entirety. Do not alter this document except to fill in the blanks and check the boxes provided, or this Stop Loss Application and Disclosure Statement will not be accepted. Sign and return the completed Stop Loss Application and Disclosure Statement to your sales representative.

APPLICATION AND DISCLOSURE STATEMENT IS HEREBY MADE FOR STOP LOSS INSURANCE based upon the following statements and representations:

Stop Loss Application and Disclosure Statement are applicable to plans selected on the Kaiser Permanente Level Funded Application and Banking Arrangements.

- Stop Loss Policy effective date is the same as the plan effective date.
- Number of covered participants is reflected on the Kaiser Permanente Level Funded Application and Banking Arrangements in the enrollment section.
- The following riders/endorsements are included in Level Funded Stop Loss Policies:
  - Terminal Liability Rider
  - Miscellaneous Endorsement
  - [Renewal Endorsement]

(Type or Print)

1. Full legal name of Plan Sponsor:	2. Principal Office (Street, City, State, Zip):

3. AGGREGATE STOP LOSS INSURANCE BENEFIT PERIOD:

Incurred Period (Effective Date):
From _____ Through (12-Month Period)_____

Paid Period (Effective Date):
From _____ Through (15-Month Period)_____

Eligible Expenses for AGGREGATE STOP LOSS INSURANCE include services covered under the Level Funded plan.

Aggregate Limit of Liability (per Coverage Period, excess of Deductible): Not Applicable.

4. SPECIFIC STOP LOSS INSURANCE BENEFIT PERIOD:

Incurred Period (Effective Date):
From _____ Through (12-Month Period)_____

Paid Period (Effective Date):
From _____ Through (30-Month Period)_____

Eligible Expenses for SPECIFIC STOP LOSS INSURANCE include services offered under the Level Funded plan.

Specific Deductible: _____
Specific Limit of Liability (per Covered Participant, excess of Deductible): Not Applicable.

STOP LOSS APPLICATION AND DISCLOSURE STATEMENT

Legal Name of Plan Sponsor: _____

5. Disclosure Statement

The Health Insurance Portability and Accountability Act (HIPAA) permits the release of Protected Health Information for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of health care operations. Kaiser Permanente Insurance Company (KPIC) shall use the information provided by the Plan Sponsor on this Stop Loss Application and Disclosure Statement for the sole purpose of evaluating the acceptability of the risk and shall not disclose any PHI collected except in the performance of its risk evaluation.

KPIC will rely upon the information provided on this Stop Loss Application and Disclosure Statement to take underwriting action on all known risks in the categories listed below. It is the Plan Sponsor's responsibility to accurately report all claims known as of the date of this Stop Loss Application and Disclosure Statement by making a thorough review of all applicable records. Such records including but not limited to historical claims reports, disability records, current information from administrators, insurers, utilization management companies, managed care companies, and any Agent/Broker of the Plan Sponsor. In exchange, KPIC will accept the liability for any truly unknown risks in accordance with the terms of its Stop Loss Insurance Policy (if issued). This Stop Loss Application and Disclosure Statement must: (1) be completed and signed by the Plan Sponsor no more than thirty (30) days prior to the proposed Effective Date of the Stop Loss Insurance Policy; and (2) be received by KPIC within five (5) days of completion. If Plan Sponsor fails to meet the prescribed timeframes, KPIC, at its discretion, may require Plan Sponsor to resubmit the Stop Loss Application and Disclosure Statement.

Upon receipt of the completed Stop Loss Application and Disclosure Statement, KPIC will assess all data, new and previously reported, and will inform the Plan Sponsor (or authorized producer) in writing within ten (10) business days of any changes to the rates, factors, or terms of coverage. KPIC reserves the right to reject the Stop Loss Application and Disclosure Statement and/or rescind the proposal in its entirety based upon a review of all information submitted during the proposal process.

For KPIC to consider issuance of a Stop Loss Insurance Policy, the Plan Sponsor shall disclose the pertinent details regarding all individuals eligible for coverage (including their eligible dependents) under the Plan Sponsor's self-funded benefit plan who meet the following criteria:

Individuals who have reached 50% of the Specific Deductible. If an individual has reached 50% of the Specific Deductible based on the total of unprocessed, pending, and/or paid claims, that individual shall be reported in Section 1 of this Stop Loss Application and Disclosure Statement.

Individuals who are utilizing extended sick leave, vacation time, Family Medical Leave Act (FMLA), or other medical leave-of-absence and/or who may be currently confined on an inpatient basis. Such individuals shall be listed in Section 2 of this Stop Loss Application and Disclosure Statement. To effectively report such individuals, the Plan Sponsor agrees to validate open cases with its TPA, Broker, Human Resources department, Precertification Company, and Large Case Management vendor, regarding any open cases.

Individuals who shall be reported due to "trigger" diagnosis and high-cost drugs. Individuals meeting this criteria shall be reported in Section 3 of this Stop Loss Application and Disclosure Statement. This shall include all eligible employees and their eligible dependents with a history or current diagnosis of any serious disease or disorder, including BUT NOT LIMITED TO: cancer, diabetes, heart disease, AIDS and AIDS Related Complex (ARC), leukemia, muscular/neuro-diseases, high risk pregnancy, organ transplants, taking high-cost-drugs, etc. For a more formal listing, please refer to the "Examples of "Trigger" Diagnoses and High-Cost Drugs for Potentially High-Dollar Claims" as set forth on page 6 of this Stop Loss Application and Disclosure Statement.

Disabled Individuals. Disabled individuals whether on temporary, short-term, or long-term disability shall be reported in Section 4 of this Stop Loss Application and Disclosure Statement.

STOP LOSS APPLICATION AND DISCLOSURE STATEMENT

Please complete the disclosure sections that follow. Use additional forms if necessary to make full and complete disclosure.

(See page 6 for ***Examples of "Trigger" Diagnoses and High-Cost Drugs for Potentially High-Dollar Claims)***

Legal Name of Plan Sponsor: _____

Please check:
"None" if there are no individuals to report for a specific section.
"Unknown" if the information is not known.
"Yes" if applicable and fill out details below.

SECTION 1: Individuals who have reached 50% of the Specific Deductible: ☐ None ☐ Yes ☐ Unknown

(Please print or type) Indicate "Employee" or "Dependent" Only	Sex (M/F)	Date of Birth	Diagnosis or High-Cost Drug	Beginning Date of Treatment	Amount of Paid Claims in Last 12 Months	Incurred and/or pending claims	Estimated future claims
1.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							
2.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							
3.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							

SECTION 2: Individuals on extended sick leave, vacation time, FMLA, or other medical leave of absence and/or who may be currently confined on an inpatient basis: ☐ None ☐ Yes ☐ Unknown

(Please print or type) Indicate "Employee" or "Dependent" Only	Sex (M/F)	Date of Birth	Date of Disability	Date Expected to Return to Work	Amount of Paid Claims in Last 12 Months	Incurred and/or pending claims	Estimated future claims
1.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
2.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
3.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							

STOP LOSS APPLICATION AND DISCLOSURE STATEMENT

Legal Name of Plan Sponsor: _____

Please check:
"None" if there are no individuals to report for a specific section.
"Unknown" if the information is not known.
"Yes" if applicable and fill out details below.

SECTION 3: Individuals who shall be reported due to "trigger" diagnosis and/or taking high-cost drugs as listed on page 6: ☐ None ☐ Yes ☐ Unknown

(Please print or type) Indicate "Employee" or "Dependent" Only	Sex (M/F)	Date of Birth	Diagnosis or High-Cost Drug	Beginning Date of Treatment	Amount of Paid Claims in Last 12 Months	Incurred and/or Pending Claims	Estimated Future Claims
1.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							
2.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							
3.					$	$	$
Current Status and Prognosis ☐ Individual has terminated							

SECTION 4: Disabled Individuals: ☐ None ☐ Yes ☐ Unknown

(Please print or type) Indicate "Employee" or "Dependent" Only, including dependent children over the age of 26	Sex (M/F)	Date of Birth	Date of Disability	Date Expected to Return to Work	Amount of Paid Claims in Last 12 Months	Incurred and/or Pending Claims	Estimated Future Claims
1.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
2.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
3.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							

STOP LOSS APPLICATION AND DISCLOSURE STATEMENT

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Please check:
"None" if there are no individuals to report for a specific section.
"Unknown" if the information is not known.
"Yes" if applicable and fill out details below.

SECTION 5: COBRA Participants: ☐ None ☐ Yes ☐ Unknown

(Please print or type) Indicate "Employee" or "Dependent" Only	Sex (M/F)	Date of Birth	Date COBRA Began	Date Expected COBRA to End	Amount of Paid Claims in Last 12 Months	Incurred and/or Pending Claims	Estimated Future Claims
1.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
2.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							
3.					$	$	$
Diagnosis, Prognosis, and Current Status ☐ Individual has terminated							

SECTION 6: Current Claims or other Administrator(s) (Please print or type)

Administrator(s)	Contact Person	Telephone Number	Type of Claims Administered/Services Rendered

Examples of "Trigger" Diagnoses and High-Cost Drugs for Potentially High-Dollar Claims

The following examples of diagnoses and high-cost drugs could potentially result in a high-dollar claim. High-dollar claims are injuries, illnesses, diseases, diagnoses, or high-cost drugs that are reasonably likely to result in a significant medical expense claim or disability.

1. **Transplants/Dialysis**
   - All organ transplants
   - Organ rejection
   - Renal failure/end stage renal disease

2. **Neonatal Conditions**
   - Biliary atresia
   - Bronchopulmonary dysplasia
   - Cystic fibrosis
   - Extreme immaturity/premature birth
   - Hydrocephalus
   - Major or multiple congenital anomaly
   - Meningomyelocele
   - Respiratory distress and in ICU over one week
   - Spina bifida
   - **High risk pregnancies and obstetrical patients with:**
     - Any request for home uterine monitoring
     - Bleeding during pregnancy
     - Expected multiple births
     - Previous history of neonatal ICU-confined infant
     - Toxemia (hypertension) requiring hospitalization during pregnancy

3. **Neurological Disorders**
   - Anoxic brain damage
   - Anoxic encephalopathy
   - Brain tumors
   - Cerebral aneurysm or AV malformation
   - Cerebral palsy
   - Guillain-Barré syndrome (GBS)
   - Lou Gehrig's disease/ALS
   - Meningitis or encephalopathy
   - Multiple sclerosis (MS)
   - Muscular dystrophy
   - Paraplegia
   - Quadriplegia
   - Reye's syndrome
   - Stroke/CVA
   - TIA (Transient Ischemic Attack)

4. **Traumatic Injuries**
   - Amputations
   - Burns or frostbite (child over 10%, adult over 20%)
   - Closed head injuries
   - Crush injuries
   - Multiple trauma or fractures
   - Spinal cord injuries

5. **Psycho-Neurotic Impairments**
   - Any confinement of 7 days or greater

6. **Blood Diseases/Disorders**
   - Aplastic anemia
   - Coagulation defects
   - Hemophilia
   - Immune deficiencies

7. **Malignancies**
   - All malignancies
   - Hodgkin's disease/non-Hodgkin's lymphoma
   - Kaposi's sarcoma
   - Leukemia
   - Multiple myeloma
   - Multiple surgeries
   - Radiation or chemotherapy treatment

8. **Cardiovascular Conditions**
   - Cardiac bypass
   - Cardiomyopathy
   - Congestive heart failure
   - Endocarditis
   - Heart failure
   - Intractable angina
   - Ischemic heart disease
   - Myocardial infarction (MI)
   - Peripheral vascular disease with pending amputation
   - Primary pulmonary hypertension
   - Ruptured abdominal aortic aneurysm

9. **Respiratory Conditions**
   - Chronic bronchitis or asthma
   - Chronic obstructive pulmonary disease (COPD)
   - Cystic fibrosis
   - Emphysema
   - Pulmonary collapse
   - Respirator dependency, any cause

10. **Infectious Diseases**
    - AIDS/HIV
    - Hepatitis C
    - Pneumocystis carinii pneumonia
    - Septicemia
    - Toxoplasmosis
    - Tuberculosis
    - Viral encephalitis

11. **Other Diseases**
    - Alpha-1 antitrypsin deficiency
    - Cirrhosis of liver/Chronic liver disease
    - Crohn's disease
    - Diabetes mellitus
    - Gaucher's disease
    - Home IV antibiotic therapy
    - Hyperalimentation
    - Lupus
    - Morbid obesity
    - Psoriasis
    - Requests for transfer to rehab facility
    - Seizures/convulsions

High-Cost Drugs

High-Cost Drugs are those drugs whose monthly costs exceed $950 for a 30-day equivalent ingredient cost. Examples of High-Cost Drugs include but are not limited to the following:

Avastin	Iclusig	Taltz
Berinert	Kalbitor	Technivie
Cinryze	Kalydeco	Tyvaso
Daklinza	Keytruda	Uptravi
Epclusa	Kynamro	Ventavis
Firazyr	Lumizyme	Viekira
Gleevec (imatinib)	Opdivo	Xyrem
H.P. Acthar	Orkambi	Yervoy
Harvoni	Soliris	Zaltrap
Humira	Sovaldi	Zepatier
Ibrance	Stelara	

Conditions leading to use of High-Cost Drugs may include but are not limited to the following: enzyme deficiencies (genetic mutations, hereditary angio-edema, Hunter's Syndrome, and others), various cancers, cystic fibrosis, multiple sclerosis, nephrotic syndrome, psoriasis and other inflammatory conditions, hepatitis C, hemophilia A, B, and C, hemolytic uremia syndrome, MDS, narcolepsy, and pulmonary arterial hypertension.

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Legal Name of Plan Sponsor: _____

If the Plan Sponsor fails to disclose any risk known to fall into one of the above categories, either intentionally or for any other reason, including failure to conduct a thorough review of all records, then KPIC may take actions that include but are not limited to: recalculating premium and/or claim factors back to the Effective Date of the Policy, modifying the terms and conditions of the Policy, terminating the Policy back to the Effective Date, recovering amounts KPIC paid as a result of relying upon this information, and pursuing prosecution to the fullest extent of the law.

The Plan Sponsor named below represents, through its authorized person, that the above list is true, complete, and accurate and none of the requested information has been omitted. You agree to provide, at KPIC's request, any additional information KPIC may require to evaluate risks. You acknowledge that intentionally providing false information, withholding or misstating material facts, or failing to provide requested information may result in the revision of rescission of the Policy. Plan Sponsor authorizes KPIC to use the information supplied on this Stop Loss Application and Disclosure Statement in evaluating and determining the acceptability of the risk as set forth in this form.

I UNDERSTAND AND AGREE, on behalf of the Applicant, that the statements in this Stop Loss Application and Disclosure Statement, and other information provided to the Company for the purposes of underwriting coverage under the Policy, are complete and true. All statements will be deemed representations and not warranties, and no such statement shall be used in defense to a claim unless it is contained in this Stop Loss Application and Disclosure Statement. I have read and understand the Fraud Statements included with this Stop Loss Application and Disclosure Statement. Coverage under the Policy will not become effective until the Stop Loss Application and Disclosure Statement is approved, and a Stop Loss Insurance Policy is issued by the Company.

Dated at _____State of _____on the _____day of _____ 20_____
(City) (Month) (Year)

Broker Representative
Licensed Broker Representative (Please Print Full Name): _____

License Number/State: _____

Signature: _____

Plan Sponsor
Legal name of Plan Sponsor (please print): _____

Representative name: _____ Title: _____

Signature: _____ Date: _____

Fraud Statements:
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.
Georgia: Any natural person who knowingly and willfully with intent to defraud subscribes, makes, or concurs in making any annual or other statement required by law to be filed with the Commissioner containing any material statement which is false commits the crime of insurance fraud.
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.
Oregon and Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.