HM LIFE INSURANCE COMPANY

P.O. Box 535057
Pittsburgh, PA 15253-5057
Tel: 800-328-5433 | Fax: 412-544-1246
hmig.com

Provider Excess Loss Insurance Application

Please Type or Print – Must be completed in full.

APPLICANT INFORMATION

Full Legal Name of Group (*to appear on Policy*)			Tax ID Number
Address	City	State	ZIP Code + 4
Delivery Address (*if different than above*)	City	State	ZIP Code + 4
Requested Effective Date:	Requested Coverage: ☐ Hospital Only ☐ Physician Only ☐ Combined		

PRODUCER (*Agent/Broker*)

Agency Name	License Number(s) – *attach a copy, if not on file*		Tax ID Number
Key Contact Person	Email Address		City
Address	City	State	ZIP Code + 4

REQUIRED DATA *(The following items must be submitted prior to or with this Application)*

1. **CAPITATION AGREEMENT(S):** Include executed copies of Capitation Agreement(s) along with the financial responsibility matrices for each such Capitation Agreement(s) to be covered.
2. **INTERMEDIARY AGREEMENT(S):** All Intermediary Agreements and all other agreements that may define the Policyholders risk sharing arrangements and obligations under the Covered Plan and Capitation Agreements.
3. **HISTORICAL UNDERWRITING INFORMATION WITHIN 45 DAYS OF THE REQUESTED EFFECTIVE DATE:**
   - For the **four (4) most recent policy periods**:
     a) Claims detail for all members who exceed 50% of the lowest Specific Deductible amount being requested; and
     b) Historical member months by population;
   - Disclosure for the **current** year-to-date period:
     a) A listing of members who have been approved or who are under evaluation for an organ or tissue transplant;
     b) **Members** Hospital confined for 30 or more consecutive days as of the date coverage is bound (Not applicable to physician-only accounts); &
     c) **Members** Planned or Undergoing treatment which may, in the opinion of the Applicant's chief medical office or other authorized clinician, result in incurred charges exceeding 50% of the lowest Specific Deductible amount requested.
4. **OTHER:** Any other data requested needed to properly process underwrite and rate the Application for provider excess loss insurance coverage.

APPLICANT UNDERSTANDS AND AGREES THAT

Our approval, final Premium Rates, and Policy Issuance are subject to: 1) receipt and review of the Required Data outlined above, 2) the first month's premium, and 3) any other information requested in connection with this Application. Failure to do so will result in approval being denied or delayed until a later date.

a) Should subsequent information become known which, if known as of the date specified by **HM Life Insurance Company**, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant.
b) Changes to the Capitation Agreement(s) during the Policy Period must be reported to Us. If changes to the Capitation Agreement differ from what was initially utilized to underwrite the risk coverage terms, including but not limited to premium rates and deductibles, such may be subject to re-rating, retro-active to the requested effective date.
c) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that **HM Life Insurance Company**, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant. Subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud. The Provider Excess Loss Insurance is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Coverage will not be in effect until notified in writing by HM Life Insurance Company. Do not cancel prior coverage until so notified.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life Insurance Company's** approval of the requested Provider Excess Loss Insurance. You and We agree that this Application replaces any prior application made for the same Policy.

Applicant's Initials: ______

FRAUD NOTICE (Please read carefully)

Warning: In **Arkansas**, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
We certify that the above information is correct and that the claims have been paid in accordance with the plan.

PLEASE SAVE, PRINT, SIGN AND RETURN THE APPLICATION VIA MAIL, EMAIL OR FAX

This Application must be signed by an Authorized Representative of the Company who is authorized to execute this Application and legally bind the Company. I hereby agree to the terms as stated above and warrant that I am duly authorized to execute this Application:

____
Printed Name of Applicant's Authorized Representative

____
Title

______________________________ __________
Signature of Applicant's Authorized Representative Date

____
Printed Name of Witness

______________________________ __________
Signature of Witness (Licensed Producer) Date

On behalf of **HM Life Insurance Company**:

____
Printed Name of Authorized Representative

____
Title

______________________________ __________
Signature of Authorized Representative Date

____
Printed Name of Witness

______________________________ __________
Signature of Witness Date

Applicant's Initials: ______