

## HM Stop Loss Application for Insurance

Please Type or Print – Must be completed in full.

APPLICANT INFORMATION					
Full Legal Name of Group <i>(to appear on Policy)</i>			Key Contact Person		
Tax ID Number		Business Telephone Number		Fax Number	
Email			Internet		
Address		City	State	Zip Code + 4	County
Delivery Address <i>(if different than above)</i>			City		State
Nature of Business		SIC Code <b>N/A</b>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership	
		<input type="checkbox"/> Government	<input type="checkbox"/> Other*: _____		

\*If an Association, Trust or Charitable Organization, a copy of the bylaws and/or trust is required with the submission of the application. If a union, or if union employees are covered, a copy of the collective bargaining agreement is required with the submission of the application.

Affiliates to be insured? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If "yes," complete the table below. Attach additional sheets if necessary.					
<b>AFFILIATE #1</b>	Full Legal Name			Nature of Business	
Address		City		State	Zip Code
<b>AFFILIATE #2</b>	Full Legal Name			Nature of Business	
Address		City		State	Zip Code
<b>AFFILIATE #3</b>	Full Legal Name			Nature of Business	
Address		City		State	Zip Code

THIRD PARTY ADMINISTRATOR <i>(Complete the table below for each administrator. Attach additional sheets if necessary.)</i>					
Full Legal Name of Third Party Administrator (TPA)					
Tax ID Number		Business Telephone Number		Fax Number	
Address		City		State	Zip Code + 4
Delivery Address <i>(if different than above)</i>			City		State
Key Contact Person		Email		Internet	

Applicant's Initials: \_\_\_\_\_

Are there prior TPAs?  Yes\*  No \*If "yes," insert the TPA name below. Attach additional sheets if necessary.

Prior TPA	will be responsible for the payment of all run-in claims on the specific and aggregate (if applicable)
Prior TPA	will be responsible for the payment of all run-in claims on the specific and aggregate (if applicable)

**PRODUCER (Agent/Broker)**

Name		License Number(s) – Please attach a copy, if not on file.			
Tax ID Number	Business Telephone Number	Fax Number	Email	Internet	
Address		City	State	Zip Code + 4	
Requested Effective Date					
Estimated Initial Enrollment	Single:	Family:	Total:		

**Premium Deposit of \$\_\_\_\_\_ included.** Estimated 1<sup>st</sup> month's premium must be attached to this application. The Premium Deposit will be applied to the first premium when due. Make check payable to **HM Life Insurance Company**. Do not make the check payable to the agent or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

**FRAUD NOTICE (Please read carefully)**

In Vermont, any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act.

**APPLICANT UNDERSTANDS AND AGREES THAT**

The stop loss insurance requested and requested effective date must be approved by **HM Life Insurance Company** as under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of Disclosure, if required, the first month's premium, final census, Claim Information, and 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.

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.

**Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.**

Final premium rates will be determined on the basis of Disclosure, if required, Claim Information and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. 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. 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.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within [60] days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application 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.

Issuance of the Policy is in reliance of the data, including Disclosure, census and Claim Information, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

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 stop loss insurance.

Applicant's Initials: \_\_\_\_\_

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

---

Printed Name of Applicant's Authorized Representative

---

Signature of Applicant's Authorized Representative

Date

Title

---

Signature of Witness (Licensed Producer)

Printed Name of Witness