DISCLOSURE STATEMENT

Participant(s) shall include all active employees, COBRA beneficiaries and their dependents, retirees (if applicable) and disabled persons. Individuals required to be disclosed are (a) All employees and dependents who are medically confined (b) All high dollar claimants and (c) All claimants with potentially catastrophic medical conditions.

Full Legal Name of Applicant (Plan Sponsor)

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PARTICIPANTS

Please list any Participant(s) who have paid or pending claims in excess of 50% of the specific deductible during the past 12 months or could reasonably be expected to have claims in excess of this amount. This should include any Participant(s) known to have cancer, immune or genetic disorder, severe cardiovascular disease, any severe disorder of a major organ system, severe burns or trauma, neonatal disorders, brain or spinal injuries, potential organ transplant, or taking high dollar medication. If the diagnosis or course of treatment of a disclosed individual changes prior to the effective date, we reserve the right to re-evaluate the risk and place a separate individual specific deductible on that individual, if necessary.

Name	Birth Date	Date of Disability	Diagnosis/ Prognosis	Current Treatment	Amounts Paid/ Pending	Currently Confined

DISABLED PERSONS AND RETIREES: (Please note "None" if there are not any.)

Disabled Persons are those employees not actively at work (or, in the case of a dependent or continuation beneficiary, is by disability unable to perform his or her normal functions of a person of like sex and age) on the effective date of this contract or the date such person becomes eligible for coverage under the employee benefit plan.

Name	Birth Date	Date of Disability	Diagnosis/ Prognosis	Current Treatment	Amounts Paid/ Pending	Currently Confined

COBRA PARTICIPANTS: (Please note "None" if there are not any.)

Name	COBRA Effective Date	Reason

FULLY INSURED TAKEOVERS: (Please note "None" if there are not any.)

Please list any Participant(s) who are not currently active at work/life. This should include anyone on COBRA, FMLA, sick leave (paid or unpaid), sabbaticals, salary continuance of any kind, LTD or STD; in addition, anyone who has missed more than 5 days of work in the most recent 12 months. This should include start/end date and reason for the leave. If the diagnosis or course of treatment of a disclosed individual changes prior to the effective date, we reserve the right to re-evaluate the risk and place a separate individual specific deductible on that individual, if necessary.

Name	Birth Date	Date of Disability	Reason For leave	Current Treatment	Days Missed	Currently Confined

Please attach a separate sheet for shock loss claims, disabled persons, retirees or COBRA participants if additional space is needed.

BRM's quote is based upon the request for proposal submitted, including the claims experience, IMQs, and all supporting data. Any inaccuracies in the data and experience submitted may necessitate either revision or rescission of the quote(s). Coverage will not be bound until BRM's underwriting department can review all requested information and all disclosure information. Coverage will be bound upon review and acceptance of this information by BRM.

The Plan Sponsor, through its authorized representatives, 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.

I have reviewed this completed form and the information given is complete and accurate, to the best of my knowledge. I understand that if the information given is not complete and accurate, the excess loss coverage proposed may be re-evaluated and Participants not disclosed may be individually underwritten retroactively to the effective date. The Insurer(s) reserves the right to terminate or limit the Participant's participation in the Policy, change or modify the Premium Rates or Specific Deductible Amount(s), or adjust the terms of the Specific and Aggregate Stop Loss coverage quoted. The Plan Sponsor further acknowledges, understands and agrees that the information provided herein 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 person(s) unless specifically agreed in writing by the Insurer(s).

This information shall be treated confidentially.

Plan Sponsor: ____________________ Third Party Administrator: ____________________

Officer's Signature: ____________________ Signature: ____________________

Name/Title: ____________________ Name/Title: ____________________

Date: ____________________ Date: ____________________