

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
Company Tracking Number: AH-30001  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Filing at a Glance

Company: Starr Indemnity & Liability Company

Product Name: AH-30001 Starr Indemnity & Liability Stop Loss SERFF Tr Num: MCHX-126070179 State: ArkansasLH

Liability Stop Loss

TOI: H21 Health - Other

SERFF Status: Closed

State Tr Num: 41768

Sub-TOI: H21.000 Health - Other

Co Tr Num: AH-30001

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting

Disposition Date: 03/12/2009

Date Submitted: 03/11/2009

Disposition Status: Approved-Closed

Implementation Date Requested: 04/12/2009

Implementation Date:

State Filing Description:

## General Information

Project Name: AH-30001 Starr Indemnity & Liability Stop Loss

Status of Filing in Domicile: Pending

Project Number: AH-30001 Starr Indemnity & Liability Stop Loss

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: to be filed concurrently

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/12/2009

Explanation for Other Group Market Type:

State Status Changed: 03/12/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

STARR INDEMNITY & LIABILITY COMPANY

NAIC No. 38318 FEIN No. 75-1670124

Excess Loss Insurance Program

AH-30001, et al Excess Loss Insurance Policy

Please see attached Forms Listing



SERFF Tracking Number: MCHX-126070179 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
 Company Tracking Number: AH-30001  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
 Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - McHughConsulting)

Jane Neal, Compliance Assistant mcr@mchughconsulting.com  
 McHugh Consulting Resources (215) 230-7960 [Phone]  
 Doylestown, PA 18901 (215) 230-7961[FAX]

### Filing Company Information

Starr Indemnity & Liability Company CoCode: 38318 State of Domicile: Texas  
 90 Park Avenue 7th Floor Group Code: Company Type:  
 New York , NY 10016 Group Name: State ID Number:  
 (212) 230-5043 ext. [Phone] FEIN Number: 75-1670124  
 -----

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Starr Indemnity & Liability Company	\$50.00	03/11/2009	26323975

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
Company Tracking Number: AH-30001  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/12/2009	03/12/2009

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
Company Tracking Number: AH-30001  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Disposition

Disposition Date: 03/12/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
 Company Tracking Number: AH-30001  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
 Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Authorization Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	Form Listing	Approved-Closed	Yes
<b>Form</b>	Excess Loss Insurance Policy	Approved-Closed	Yes
<b>Form</b>	Application for Excess Loss Policy	Approved-Closed	Yes
<b>Form</b>	Schedule of Excess Loss Coverage	Approved-Closed	Yes
<b>Form</b>	Policyholder Acceptance	Approved-Closed	Yes
<b>Form</b>	Aggregating Specific Deductible	Approved-Closed	Yes
<b>Form</b>	Endorsement		
<b>Form</b>	Specific Terminal Liability Endorsement	Approved-Closed	Yes
<b>Form</b>	Aggregate Accommodation Endorsement	Approved-Closed	Yes
<b>Form</b>	Aggregate Terminal Liability Endorsement	Approved-Closed	Yes
<b>Form</b>	Individuals Excluded Under Excess Loss	Approved-Closed	Yes
<b>Form</b>	Coverage Endorsement		
<b>Form</b>	Rate Stabilization Endorsement	Approved-Closed	Yes
<b>Form</b>	Aggregate Quota Share Endorsement	Approved-Closed	Yes
<b>Form</b>	Specific Advance Endorsement	Approved-Closed	Yes
<b>Form</b>	Arkansas Policy Endorsement	Approved-Closed	Yes

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
 Company Tracking Number: AH-30001  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
 Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Form Schedule

**Lead Form Number:** AH-30001

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AH-30001	Policy/Cont	Excess Loss ract/Fratern Insurance Policy al Certificate	Initial		42	AH-30001.PDF
Approved-Closed	AH-30002-AR	Application/	Application for Enrollment Excess Loss Policy Form	Initial		42	AH-30002-AR.PDF
Approved-Closed	AH-30003	Schedule	Schedule of Excess Pages Loss Coverage	Initial		42	AH-30003.PDF
Approved-Closed	AH-30005	Other	Policyholder Acceptance	Initial		42	AH-30005.PDF
Approved-Closed	AH-30006	Certificate	Aggregating Specific Amendmen Deductible t, Insert Endorsement Page, Endorseme nt or Rider	Initial		42	AH-30006.PDF
Approved-Closed	AH-30008	Certificate	Specific Terminal Amendmen Liability Endorsement t, Insert Page, Endorseme nt or Rider	Initial		42	AH-30008.PDF
Approved-Closed	AH-30009	Certificate	Aggregate Amendmen Accommodation t, Insert Endorsement Page, Endorseme nt or Rider	Initial		42	AH-30009.PDF
Approved-Closed	AH-30010	Certificate	Aggregate Terminal Amendmen Liability Endorsement t, Insert	Initial		42	AH-30010.PDF

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
 Company Tracking Number: AH-30001  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
 Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

Page,  
 Endorseme  
 nt or Rider

Approved- Closed	AH-30011	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Individuals Excluded Under Excess Loss Coverage Endorsement	Initial	42	AH- 30011.PDF
Approved- Closed	AH-30012	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Rate Stabilization Endorsement	Initial	42	AH- 30012.PDF
Approved- Closed	AH-30013	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Aggregate Quota Share Endorsement	Initial	42	AH- 30013.PDF
Approved- Closed	AH-30014	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Specific Advance Endorsement	Initial	42	AH- 30014.PDF
Approved- Closed	AH-30001- END-AR	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Arkansas Policy Endorsement	Initial	42	AH-30001- END-AR.PDF



**Starr Indemnity & Liability Company  
Administrative Office:  
[90 Park Avenue  
7<sup>th</sup> Floor  
New York, NY 10016]**

**EXCESS LOSS INSURANCE POLICY  
Non – Participating**

**Please Read This Policy Carefully**

**Policyholder:** [ABC Company]

**Principal Address:** [345 Broad St., Anytown, USA]

**Policy Number:** [12345]

**Effective Date:** [05.01.09]

**Expiration Date:** [04.30.10]

**Designated Claims Administrator(s)/ Third Party Administrator(s):**  
[XYZ Administrative Services, Inc.  
789 Main St., Anytown, USA]

This Policy is issued in consideration of the Policyholder's Application, Disclosure Statement, and the payment of premiums. This Policy, Application, Disclosure Statement, and a copy of Policyholder's Employee Welfare Benefit Plan on file with Starr Indemnity & Liability Company (SILC) form the entire agreement between the Policyholder and SILC.

All periods of coverage will begin and end at 12:01a.m.local time at the Policyholder's Principal Address.

This Policy is governed by the laws of the state of the Policyholder's Principal Address except to the extent which is pre-empted by ERISA.

**IN WITNESS WHEREOF** SILC has caused this Policy to be executed and attested, but this Policy shall not be valid unless countersigned by a duly authorized representative of the Company.



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

**TABLE OF CONTENTS**

Schedule of Excess Loss Coverage .....

SECTION I            Definitions .....

SECTION II           Effective Date of Coverage .....

SECTION III          Specific Excess Loss Coverage .....

SECTION IV          Aggregate Excess Loss Coverage .....

SECTION V           Reimbursement of Additional Coverages.....

SECTION VI          Limitations .....

SECTION VII          Exclusions.....

SECTION VIII        Premiums and Factors.....

SECTION IX          Termination.....

SECTION X           Reinstatement.....

SECTION XI          Claim Requirements.....

SECTION XII         General Provisions.....

Exhibit I

## SECTION I

### DEFINITIONS

**Actively at Work** means that an employee is performing the ordinary duties of his or her job and is not confined to a hospital or other health care facility, or as defined by the Plan Document, or absent from the workplace because of any illness or accident. Ordinarily, scheduled vacation time is considered to be Actively at Work.

**Aggregate Reimbursement Percentage** means the percentage at which Eligible Expenses, in excess of the Annual Aggregate Attachment Point, will be reimbursed by the Company.

**Aggregating Specific Deductible** means the amount retained and Paid by the Policyholder during the Policy Period for Plan Benefits, which are in excess of the Specific Attachment Point, equal to Plan Benefits in excess of the Specific Attachment Point multiplied by the Specific Reimbursement Percentage.

**Annual Aggregate Attachment Point** means, for the Policy Period, the Plan Benefits covered by this Policy and wholly retained by the Policyholder. It is not considered for reimbursement under this Policy, and is the greater of:

1. the sum on Monthly Aggregate Factor amounts for each month of the Policy Period, determined by multiplying the total number of Covered Units by the Monthly Aggregate Factor amounts; or
2. the Minimum Annual Aggregate Attachment Point shown in the Schedule.

The maximum per Covered Person, or Covered Family, as indicated in the Schedule, which may be applied annually to the Annual Aggregate Attachment Point, (i.e. Claim Limit) is shown in the Schedule.

**Application** means that Excess Loss Insurance Application signed by the Policyholder and attached to this Policy. The Application is subject to acceptance by the Company and, if accepted, will become a part of this Policy.

**Benefit Period** means the period of time during which Eligible Expenses must be Incurred by a Covered Person, or Covered Family, as indicated in the Schedule, and Paid by the Policyholder to be eligible for reimbursement under this Policy. This period does not alter the Policy Effective Date or Policy Period. It does not waive this Policy's eligibility requirements.

**Claim Limit** means the maximum amount of payments for Eligible Expenses that will be counted for any one Covered Person, or Covered Family, as indicated in the Schedule.

**Claims Administrator/Third Party Administrator (TPA)** means a firm having a written agreement with the Policyholder to process Plan Benefits and provide administrative services.

The terms Claims Administrator or Third Party Administrator, as used in this Policy, does not refer to the Plan Administrator used in the Employee Retirement Income Security Act (ERISA) of 1974, as amended, unless the Policyholder specifically appointed the Claims Administrator/Third Party Administrator as such.

**COBRA Beneficiary** means a Covered Unit that elects to extend its group health coverage under the Plan as entitled under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

**Company** means Starr Indemnity & Liability Company (SILC).

**Covered Family** means an employee and his or her dependents covered under the Plan.

**Covered Person** means an individual covered under the Plan.

**Covered Unit** means an employee, and employee with dependents, or such other defined unit as agreed upon between the Policyholder and the Company, as shown in the Application. (Existing in any Policy Month)

**Disabled Persons** are those persons who are or become unable to perform the same lifestyle functions as a person of similar age and sex who is in good health.

**Eligible Expenses** means the eligible charges payable under the Plan and for which the Covered Person is liable to pay. It does not include expenses specifically excluded or limited by this Policy, Application for this Policy, or any Endorsements.

**Endorsement** means a written amendment or addendum that alters the terms of this Policy.

**[Experimental or Investigational** means medical services, supplies or treatments provided or performed in a special setting for research purposes, under a treatment protocol or as part of a clinical trial (Phase I, II, or III). The covered service will also be considered Experimental/Investigational if the Covered Person is required to sign a consent form which indicates the proposed treatment or procedure is part of a scientific study or medical research to determine its effectiveness or safety. Medical treatment, which is not considered standard treatment by the majority of the medical community or by Medicare, Medicaid or any other government financed programs or the National Cancer Institute regarding malignancies, will be considered Experimental/Investigational. Treatment is also considered Experimental/Investigational if such treatment has not been granted, at the time services were rendered, any approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services, Food and Drug Administration (FDA), or any other comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medical Title XVII. A drug, device or biological product is considered Experimental/Investigational if it does not have FDA approval or it has FDA approval only under an interim step in the FDA process, i.e., an investigational device exemption or an investigational new drug exemption.

Notwithstanding the above, a prescription drug for a treatment that has been approved by the FDA but is used as a non-approved treatment shall not be considered Experimental or Investigational for purposes of this policy and shall be afforded coverage to the same extent as any other prescription drug; provided that the drug is recognized by one of the following as being Medically Necessary for the specific treatment for which it has been prescribed:

1. the American Medical Association Drug Evaluations;
2. the American Hospital Formulary Service Drug Information;
3. the United States Pharmacopeia Drug Information; or
4. a clinical study or review article in a reviewed professional journal.]

**Incurred** means:

1. with respect to medical services or supplies, the date on which the services are rendered or supplies are received by the Covered Person; and
2. with respect to disability income benefits, the date each periodic benefit payment becomes payable to the Covered person (not the date the disability commences).

**Late Entrant** means a Covered Person whose coverage under the Plan was initiated at any time other than during initial enrollment after first becoming eligible, or during the Plan's annual open enrollment period, except where HIPAA requires such Plan to permit late enrollment.

**Large Claim** means Paid, pending, or denied (include reasons for denial) claims reaching, or with the potential to reach, 50% of the Specific Attachment Point.

**Minimum Annual Aggregate Attachment Point** means the lowest amount of total Payment the Policyholder must make under the Plan before the Policyholder is eligible for reimbursement under Aggregate Excess Loss coverage. The Minimum Annual Aggregate Attachment Point is shown in the Schedule.

**Monthly Aggregate Factor** means the factor(s) which is/are multiplied by the number of Covered Units for each Policy Month to determine the Annual Aggregate Attachment Point. The monthly Aggregate Factor(s) is/are shown in the Schedule.

**Paid, Pay, Payment** means that a claim has been adjudicated by the Claims Administrator/TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional and direct payment of a claim to a Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. the payor directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. the account upon which the payment is drawn contains, and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which is drawn.

**Plan** (Employee Welfare Benefit Plan) means the self-insured health care plan the Policyholder agreed to make available to their employees and eligible dependents.

**Plan Benefits** means the health benefits covered by the Plan during the Policy Period which are:

1. Incurred on or after the Effective Date of this Policy; and
2. Incurred while this Policy is in force; and
3. Incurred and Paid during the Policy Period.

Plan Benefits will also include those health benefits covered by the Plan during the Policy Period which are Paid during any Run-Out-Period or Incurred during any Run-In-Period applicable to this Policy.

Plan Benefits do not include:

1. deductibles of the Plan;
2. co-insurance or co-payment amounts of the Plan;
3. expenses that are applied toward a Health Savings Account (HSA plans);
4. expenses that are not covered by the Plan or this Policy;
5. amounts recoverable from any other source; or
6. amounts Paid under a previous policy or arrangement or excess loss coverage, whether issued by the Company or another entity.

**Plan Document** means the written instrument which describes the Plan and names the fiduciaries or trustees who jointly and separately have authority to control and manage the operations and

administration of the Plan. The Plan document must be in effect on the Effective Date of this Policy. The Plan Document shall be attached to and made a part of this Policy. Any changes to the Plan document must be approved by the Company. (See the "Changes to the Plan.")

**Policy** means this Excess Loss policy issued by the Company to the Policyholder.

**Policy Month** means, for the first Policy Month, the period beginning on the Effective Date of this Policy and ending on the corresponding date of the following month. Subsequent Policy Months begin on the corresponding date of each calendar month and continue until the corresponding date of the next month to the Policy Expiration Date.

**Policy Period** means the time period beginning on the Effective Date and ending on the Expiration Date.

**Policyholder** means the Plan Sponsor, named on the face page, to which this Policy is issued.

**Potential Catastrophic Loss** means a Paid, pending or denied claim that has the potential to be catastrophic.

**Premium Due Date** for the first monthly premium is on or before the inception date of this policy. The remaining eleven (11) monthly premiums shall be due on the date of each month that corresponds numerically with the inception date of this policy. If there is no such date in any such month, monthly premium for such month will be due on the last date of such month.

**Run-In-Limit** means the maximum benefit amount Paid by the Policyholder under the Plan for Eligible Expenses Incurred by a Covered Person during the Run-In-Period which will be applied toward payment under this Policy.

**Run-In-Period** means the period of time shown in the Schedule immediately prior to the first day of the Policy Period during which Eligible Expenses Incurred by a Covered Person, Which are Paid by the Policyholder during the Policy Period, will be considered when determining benefit payments under this Policy.

**Run-Out-Period** means the period of time shown in the Schedule immediately following this Policy's Expiration Date during which Plan Benefits Paid by the Policyholder for Eligible Expenses Incurred by a Covered Person during the Policy Period will be considered when determining benefit payments under this Policy. **If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination.**

**Schedule** means the Schedule of Excess Loss Coverage.

**Specific Attachment Point** means the amount which is retained and Paid by the Policyholder during the Policy Period. It is not considered for reimbursement under this Policy. The Specific Attachment Point applies separately to each Covered Person, or Covered Family, as indicated in the Schedule. The Specific Attachment Point is shown in the Schedule.

**Specific Lifetime Maximum Reimbursement** means the maximum amount the Company will reimburse the Policyholder with respect to any Covered Person, or Covered Family, as indicated in the Schedule, under this and prior or later Policies issued by the Company. The Lifetime Maximum excludes the Specific Attachment Point amount, and, if applicable, any amounts applied toward the Aggregating Specific Deductible. The Lifetime Maximum will not exceed the lesser of:

1. the amount shown in the Schedule; or
2. the lifetime amount set forth in the Plan.

**Specific Reimbursement Percentage** means the percentage at which Eligible Expenses, in excess of the Policyholder's Specific Attachment Point, and if applicable in excess of the Aggregating Specific Deductible, will be reimbursed of the Company.

**Usual and Customary Charges** means the common charge for the same or comparable service or supply in the geographic area in which the service or supply is furnished. Usual and Customary charges are determined based upon:

1. the amount of resources expended to deliver the treatment;
2. the complexity of the treatment rendered; and
3. charging protocols and billing practices generally accepted by the medical community.

## **SECTION II**

### **EFFECTIVE DATE OF COVERAGE**

Coverage under this Policy is not effective until:

1. payment of the first (1<sup>st</sup>) premium;
2. receipt of a signed Application for Excess Loss Insurance;
3. receipt, examination and acceptance by the Company a signed Disclosure Statement; and
4. receipt, examination and acceptance by the Company of the Plan Document and all other information which is material to underwriting or premium rating, whether or not specifically requested.

## **SECTION III**

### **SPECIFIC EXCESS LOSS COVERAGE**

The Company will reimburse the Policyholder for Plan Benefits Paid in excess of the Specific Attachment Point, and if applicable the Aggregating Specific Deductible, not to exceed the Specific Lifetime Maximum amount shown in the Schedule.

The Company will reimburse the Policyholder after the Policyholder provides an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Excess Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, or Covered Family, as indicated in the Schedule, it is the lesser of:

1. the Specific Lifetime Maximum; or
2. eligible Plan Benefit Payments made with regard to a Covered Person, or Covered Family, as indicated in the Schedule, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

In addition, the Specific Excess Loss Benefits Payable under this Policy will be reduced by the Aggregating Specific Deductible, if applicable as indicated in the Schedule.

If, for any reason, the Policyholder's Specific Excess Loss coverage terminates before the end of the Policy Period:

1. all coverages under this Policy will end immediately;
2. the Run-Out-Period, if any, will not apply; and
3. the Specific Attachment Point, and if applicable the Aggregating Specific Deductible shown in the Schedule will continue to apply and it will not be reduced.

#### **SECTION IV**

##### **AGGREGATE EXCESS LOSS COVERAGE**

The Aggregate Excess Loss benefit for the Policy Period is the Plan Benefit Payments made for Eligible Expenses during the Policy Period Less:

1. the greater of the Minimum Annual Aggregate Attachment Point or the calculated Annual Aggregate Attachment Point; and less
2. the Specific Excess Loss benefits which have been or will be reimbursed by the Company under the Specific Excess Loss Coverage except those contained in Special Limitations as identified in the Application; and less
3. any Payments which exceed any limitation of coverage under this Policy or which are excluded under this Policy; multiplied by
4. the Aggregate Reimbursement Percentage.

In no event will the Aggregate Excess Loss benefit exceed the Maximum Aggregate Reimbursement specified under Aggregate Excess Loss Coverage in the Schedule.

**If, for any reason, this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and premium paid will not be refundable.**

#### **SECTION V**

##### **REIMBURSEMENT OF ADDITIONAL COVERAGES**

Plan Benefits which the Policyholder Paid under the prescription drug plan, vision plan, or dental plan will be considered for reimbursement under Specific Excess Loss coverage only if shown as included in the Schedule.

Plan Benefits which the Policyholder Paid under the prescription drug plan, vision plan, dental plan and/or weekly disability income plan will be considered for reimbursement under Aggregate Excess Loss coverage only if shown as included in the Schedule. The most the Company will reimburse the Policyholder for Plan Benefits Paid under the weekly disability income plan, if included for reimbursement, is shown in the Schedule.

#### **SECTION VI**

##### **LIMITATIONS**

##### **Actively at Work Status and Disability Persons**

The Company will not reimburse expenses Incurred by individuals who, on the latter of the Effective Date of their coverage under the Plan or the Effective Date of this Policy:

1. are not Actively at Work, unless the Actively at /work requirement has been waived as indicated in the Schedule; or

2. are Disabled Persons, unless disclosed and accepted by the Company;
3. are excluded by name by way of an attachment to the Application or by Endorsement; or
4. are Late Entrants not accepted by the Company, except if the Late Entrant is subject to a pre-existing limitation provision in the Plan.

### **Disabled Persons**

Expenses Incurred will not be eligible to satisfy the Specific Attachment Point or the Annual Aggregate Attachment Point until the day next following the date:

1. the Covered Person, with respect to an employee, returns to work on a full-time basis as defined in the Plan; or
2. the Covered Person is no longer considered a Disabled Person; or
3. the Covered Person meets the eligibility requirements of the Plan.

This limitation only applies to Covered Persons whose coverage under the Plan is effective on or after the Effective Date of this Policy.

### **Disclosure**

The Company relied upon the information provided by the Policyholder and their Claims Administrator, (TPA) in the issuance of this Policy. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the premium, rates, factors, terms or conditions for coverage there under, the Company will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to the Policyholder. Any fraudulent statement will render this Policy null and void and claims, if any, will be forfeited.

### **Retired Employees**

The Company will reimburse Paid Plan Benefits for Retired Employees and their dependents, which are eligible under the Plan only if such persons are indicated as included in the Schedule.

### **Drug or Alcohol Abuse**

If the Plan covers treatment of drug or alcohol abuse, Plan Benefits reimbursable under this Policy for such treatment will be limited to the amount stated in the Plan.

### **Medicare Benefits**

With respect to Covered Persons who are eligible for coverage under Medicare, any benefit reimbursable to the Policyholder under this Policy shall be reduced by the amount of any similar Medicare benefit paid or reimbursable so that the total reimbursements hereunder with respect to a Covered Person shall not exceed 100% of such person's actual expenses otherwise reimbursable under this Policy.

### **Liability for Reimbursement**

The Company shall not be liable under this Policy to directly reimburse any Covered Person or provider of professional or medical services for any benefits the Policyholder agreed to provide under the terms of the Plan. The Company's sole liability is to the Policyholder, in accordance with the terms of this Policy. The Policyholder may not assign any Excess Loss benefits to Covered Persons or providers of services.

## SECTION VII

### EXCLUSIONS

The Company will not reimburse the Policyholder for any loss or expense caused by or resulting from:

- [1.] expenses Incurred while the Plan is not in force with respect to the Covered Person, or for a person not covered under the Plan;
- [2.] expenses covered by Plan changes made prior to the Company's written approval of such changes;
- [3.] expenses which result from any prescription care service, mail order prescription plan or any pre-paid prescription drug plan, dental, vision, or weekly disability income benefits, unless specifically included in the Schedule and approved by the Company;
- [4.] liability or obligations assumed by the Policyholder under any contract or service agreement other than the Plan;
- [5.] expenses for services or supplies which are in violation of any law;
- [6.] expenses for services or supplies billed above the Usual and Customary Charges for the area where provided or which are greater than the Plan benefit;
- [7.] expenses resulting from or caused by war, whether declared or undeclared, civil war, invasion, hostilities, riot or resistance to armed aggression;
- [8.] expenses for any injury or sickness arising out of, or in the course of an employment for wage or profit and for which the Covered Person is entitled to benefits under any Workers' Compensation or occupational disease law, whether or not the Covered Person has applied for such benefits;
- [9.] cost of the administration of claims, including cost of investigation, payments, or other service(s) provided by the Policyholder's Claims Administrator/TPA, consulting fees and/or expenses of any litigation;
- [10.] expenses from an act while committing, or attempting to commit an assault, a felony, or participating in an illegal occupation;
- [11.] any amount used to satisfy deductibles, coinsurance amounts, co-payments, or Health Savings Account (HSA) deductibles under the Plan;
- [12.] expenses or costs resulting from non-contractual damages, court costs and legal fees, including but not limited to compensatory, exemplary and punitive damages, fines or statutory penalties;
- [13.] medical expenses in connection with Experimental or Investigational surgery or treatment as defined in [this Policy] [the Plan];
- [14.] payments recoverable through the Plan's Coordination of Benefits or similar provision;
- [15.] expenses Incurred by an employee or dependent of an employee of any affiliated or subsidiary company not included in the Application, unless added by Endorsement;
- [16.] legal expenses and fees including legal expenses and fees Incurred on behalf of any Covered Person in obtaining medical treatment or expenses Incurred in connection with a judgment or settlement arising out of the Policyholder's negligence in providing, arranging, or failing to provide or arrange a benefit to a Covered Person;

- [17.] payments the Policyholder make under the Plan for services and supplies which are not included in the Plan or which are outside the requirement of the Plan Document;
- [18.] expenses Incurred after the Expiration Date;
- [19.] in the event this Policy is terminated before the Expiration Date, expenses Incurred after the date of such termination;
- [20.] the Claims Administrator's/TPA's failure to provide timely Payment to providers which results in non-receipt of any discounted fees for services or supplies. The Company will reimburse only for the amount of the discounted amount had timely Payment been made by the Claim Administrator, or TPA;
- [21.] expenses incurred by any COBRA beneficiary whose COBRA continuation coverage was not offered in a timely manner, or was not elected in a timely manner, or for which premiums were not paid in a timely manner.
- [22.] expenses incurred as a result of travel within any foreign country which is covered at the time of the expense by an active U.S. Department of State issued Travel Warning.
- [23.] expenses incurred as a result of human organ and/or tissue transplants unless indicated in the Schedule.
- [24.] expenses incurred by a Covered Person for the cost of drugs, procedures, services, supplies or treatments rendered or received in person, by mail or otherwise outside the United States if the purpose of such travel or communication is to obtain or receive such drug, procedure, service, supply or treatment.
- [25.] expenses which are actually Paid by the Policyholder for administrative costs, including but not limited to, administrative costs for claim payments, networks, case management fees in excess of the usual and customary charge, PPO access fees and prescription drug administration fees.

## **SECTION VIII**

### **PREMIUMS AND FACTORS**

#### **Payments of Premiums**

No coverage under this Policy will be in effect until the first premium is paid. For coverage to remain in effect, each subsequent premium must be paid on or before the Premium Due Date. The Policyholder is responsible for the payment of premiums. Payment of the premium to the Claims Administrator/TPA does not constitute payment of the premium to the Company. Premium is not considered paid until the premium check is received at the Company's Underwriting Office and sufficient funds are transferred from the Policyholder's account into the Company's account.

Upon termination of this Policy, or coverage hereunder if the earned premium exceeds the premium paid, the Policyholder will pay the excess to the Company; if less, the Company will return to the Policyholder the unearned portion of premium paid, subject to the minimum premium, if any, shown in the Schedule.

#### **Grace Period**

A Grace Period of [thirty-one (31)] days from the due date will be allowed for the payment of each premium after the first premium payment. During the Grace Period, the coverage will remain in effect, provided the premium is paid before the end of the Grace Period. If the Policyholder does not pay the premium during the Grace Period, the Policy will terminate without further notice, retroactive to the date for which premiums were last paid.

## Changes in Premium Rates or Factors

The Company may change premium rates and/or Monthly Aggregate Excess Loss Factors on any of the following dates:

1. The date when the terms of the Policy are changed.
2. The date the Policyholder adds or deletes a subsidiary or affiliated companies or divisions with the Company's approval.
3. The date the policyholder changes the Plan with the Company's written approval;
4. The date there is a change in the geographical area in which the Policyholder is located.
5. The date there is a change in the nature of business in which the Policyholder is engaged.

The Company reserves the right to recalculate the premium rates and/or the Monthly Aggregate Excess Loss Factors retroactively for the Policy Period, if there is more than [10%] variance between:

1. the number of Covered Units on any Premium Due Date; and
2. the number of Covered Units on the Policy Effective Date.

Otherwise, the Company will not change the Policyholder's premium rates or Monthly Aggregate Excess Loss Factors during the Policy Period.

## SECTION IX

### TERMINATION

This Policy and all coverage hereunder will end upon the earliest of the following:

1. At the end of any period for which the premium is paid, if the subsequent premium is not paid as provided in the Grace Period provision.
2. On the date the Policyholder advises the Company that they want to cancel this Policy, provided the Policyholder gives the Company at least thirty-one (31) days advance written notice. If the Policyholder cancels this Policy within thirty (30) days after the Effective Date, the Policyholder may request a full refund of premium, terminating the Policy on the Effective Date. If the Policyholder cancels this Policy at a later date, the Company may keep the premium earned to the date of termination.
3. The Expiration Date of this Policy.
4. On the Effective Date, if, within sixty (60) days after the Effective Date:
  - a. the Policyholder fails to provide the Company any information or materials requested by the Company; or
  - b. the Policyholder fails to comply with any condition imposed by the Company when this Policy is issued.

If so, the Company will return the premium paid by the Policyholder, less the amount of any reimbursement the Company made to the Policyholder before the time this Policy was terminated. If the amount reimbursed to the Policyholder exceeds the premium paid to the Company, the Policyholder will pay the Company the difference.

5. The date the Plan terminates.
6. The date the administrative agreement between the Policyholder and the Claims Administrator, or TPA terminates, unless the Company consent in writing to the Policyholder naming of a new Claims Administrator/TPA.
7. The last day of the third consecutive month during which the policy fail to maintain the Minimum Plan Enrollment as stated in the Schedule, unless the Company agrees in writing to continue coverage;
8. The date the Policyholder:
  - a. Suspends active business operations; or
  - b. is placed in bankruptcy or receivership, or
  - c. dissolves.
9. Any date on which the Policyholder does not pay claims or make funds available to pay claims as required by the Plan.

### **Concealment or Fraud**

This entire Policy will be void:

1. if, before or after a claim or loss, the Policyholder concealed or misrepresented any material fact or circumstance concerning this Policy, including any claim; (This includes failure to provide the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.) or
2. in any case of fraud by the Policyholder or its Claims Administrator/TPA relating to this coverage.

## **SECTION X**

### **REINSTATEMENT**

The Company may at its option approve the Policyholder's request to reinstate this Policy. The Policyholder shall submit to the Company any forms and data the Company may require, including the Policyholder's representation as to losses Incurred or Paid as of the date of the Policyholder's request for reinstatement. If this Policy is reinstated, the Policyholder shall pay to the Company the premiums due from the date this Policy terminated.

## **SECTION XI**

### **CLAIM PROVISIONS**

#### **Administration of Claims under the Plan**

The Company has no duty to settle or adjust claims filed under the Policyholder's Plan. The Policyholder must retain and pay a Claims Administrator/TPA at all times. No one, including the Policyholder, may pay benefits for the Plan unless named as the Claims Administrator/TPA on the Schedule and approved by the Company. The Company will not reimburse the Policyholder for Plan Benefits resulting from benefits paid by someone not authorized to do so.

The Policyholder must make available sufficient funds to pay benefits when due.

The Claims Administrator/TPA shall:

1. supervise the administration and adjustment of all claims and verify the accuracy and computation of all claims, in accordance with the Plan;
2. maintain accurate records of all claim Payments;
3. maintain separate records of expenses not covered; and
4. provide the Company on or before the 15<sup>th</sup> day of each Policy Month, the following data for the preceding Policy Month:
  - a. number of Covered Persons and/or Covered Units; and
  - b. a total of claim Paid.

### **Management of Large Claims and Potential Catastrophic Losses**

Notice of Large Claims and Potential Catastrophic Losses – The Policyholder or Claims Administrator or TPA must notify the Company in writing of any Large Claims or Potential Catastrophic Losses (regardless of whether charge have been Paid, are pending Payment, or if denied include the reason for denial) as soon as practically possible when the claim exceeds or it appears that the claim will reach or exceed the defined limits for a Large Claim or is potentially catastrophic. (See Exhibit I)

Failure to Notify – If for any reason Large Claim or Potential Catastrophic Loss is not properly submitted to the Claims Administrator/TPA, the Policyholder shall promptly notify the Claim Administrator/TPA of the claim. In the event the Policyholder or Claims Administrator/TPA fails to follow the notification requirements set forth in this provision, the Policyholder's losses related to such Large Claim or Potential Catastrophic Loss may not be considered for reimbursement under this Policy.

If the Policyholder receives information that any claim may be or becomes a Potential Catastrophic Loss, the Policyholder will immediately notify the Claims Administrator/TPA.

### **Notice of Claim**

Specific Excess Loss – The Policyholder must give written notice of claim to the Company within thirty (30) days of the date the Policyholder becomes aware of claims, with respect to a Covered Person, that have reach 50% of the Specific Attachment Point; however, Large Claims and Potential Catastrophic Losses should be reported within the time frame specified in the previous paragraph.

Aggregate Excess Loss – The Policyholder must give written notice of claim to the Company within thirty (30) days of the date the Policyholder becomes aware of claims that have reached the Annual Aggregate Attachment Point.

The Policyholder's failure to furnish written notice within the time required by this Policy will not invalidate or reduce any claim if it was not reasonably possible to provide written notice within such time. However, written notice must be furnished as soon as possible, but in no event late that one (1) year after the date written notice is first required.

The Policyholder or Claims Administrator/TPA shall submit on a timely basis all proofs of claims, reports and supporting documents the Company may request.

### **Proof of Loss**

Written proof of loss must be submitted within sixty (60) days after the date of loss. Late proof will be accepted only if it is shown to have been furnished as soon as reasonable possible and within one (1) year of the date of loss.

## **Payment of Claims**

Amounts payable under this Policy will be paid upon receipt and acceptance by the Company of all the required material. Required material shall include proof of loss and proof of Payment of Eligible Expenses under the Plan and any reasonably requested supporting documentation. The Company will have sole authority to reimburse or deny claims under the Policy.

## **Benefit Determination**

Determination of benefits under the Plan is the Policyholder's sole responsibility. The Company has no duty to settle or adjust claims filed under the Plan with the Policyholder or the Claims Administrator/TPA. The Company has the right to review each claim the Policyholder submits to the Company for reimbursement to determine if the Policyholder is entitled to reimbursement. Only the Company has the authority to reimburse losses covered by this Policy.

## **Recoveries/Subrogation**

The Company has the right to recover any and all payments that the Company has made to the Policyholder under this Policy from any person or entity that has been found to made, or is obligated to make in the future, a First and/or Third Party payment to the Plan participant as the result of an accident or illness caused by the negligence of another party. If the Policyholder recovers any monies from any source for any loss for which the Policyholder received payment under this Policy, the Company will be reimbursed on a priority basis from such recovery to the extent of the Company's payments to the Policyholder before the Policyholder is entitled to a recovery. This obligation of the Policyholder to the Company survives the termination of the Policy and is applicable even if the Policy has expired and/or been terminated.

In the event the Policyholder does not pursue all available recovery sources, then the Policyholder's right of subrogation against a Covered Person transfers to the Company and the Policyholder will at all times cooperate with the Company in their recovery efforts. Further, there can be no deduction of the amounts due the Company for legal fees, or any costs associated with the recovery of these payments without the expressed written agreement of the Company prior to the matter being settled or these costs being incurred. In addition, if there is to be a settlement for any portion of the funds that is less than 100% of the amount(s) paid to the Policyholder by the Company, any such agreement must first be approved by the Company, or their designated representative, before the Policyholder agrees to such a settlement with any other person or entity.

Other Insurance – The amounts otherwise payable under this Policy shall be reduced by the amount of any reimbursement or indemnity which the Policyholder may be entitled to receive with respect to the Company's liability under this Policy.

## **Notice of Appeal**

Any objection, notice of legal action, or complaint received on a claim processed under the Plan on which it reasonably appears an Excess Loss benefit will be payable to the Policyholder under this Policy shall be brought to the immediate attention of the Company.

## **SECTION XII**

### **GENERAL PROVISIONS**

#### **Entire Contract**

This entire contract consists of:

1. this Policy, including any Endorsements;

2. Policyholder's application and Schedule and any attachments thereto, a copy of which is attached to this Policy, and
3. a copy of the Policyholder's Plan

All statements made by the Policyholder or any Covered Person are, in the absence of fraud, understood to be representations and not warranties. Such statements will not be used to contest coverage unless contained in the Application and Schedule or any attachments to the Application and Schedule.

In case of a conflict between the Plan and this Policy, this Policy will prevail. The Company has relied on the information the Policyholder provided to issue this Policy. The Policyholder represents such information is accurate. Should subsequent information become known which, if known prior to issuance of this Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, the Company will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to the Policyholder. Any fraudulent statement will render this Policy null and void and claims, if any, will be forfeited.

### **Policy Nonparticipating**

This Policy does not entitle the Policyholder to share in the Company's earnings.

### **Records and Review**

The Policyholder and/or Claims Administrator/TPA must:

1. Keep appropriate records regarding administration of the Plan ;( The Policyholders records include records help by the Claims Administrator/TPA.)
2. Allow the Company to review and copy, during normal business hours, all records affecting the Company's liability under this Policy;
3. maintain records of all Covered Persons under the Plan during the Policy Period and for a period of seven (7) years after the termination of this Policy; and
4. maintain a separate record of any and all amounts the Policyholder pay that exceed or are not covered by the benefits under the Plan.

As a result of any audit, the Company may readjust premiums, attachment points or reimbursements to the Policyholder as may be necessary to reflect the Policyholder's and the Company's original intent in issuing this Policy.

### **Clerical Error**

If the policyholder or the Company makes a clerical error keeping records or calculating premiums or claims pertaining to this Policy, it will not invalidate this Policy. A clerical error will not expand the Company's obligations under this Policy. A clerical error is a mistake in performing a clerical function, and does not include intentional acts or failure to comply with Plan or Policy provisions. A clerical error is not the failure to disclose the required disclosure of health history of Disabled Persons, Large Claims or Potentially Catastrophic Losses.

### **Changes to This Policy**

Changes to this Policy may be made only by a Company officer or the Company's Underwriting Office, with the Company's approval. Any change must be by written Endorsement.

### **Changes to the Plan**

The Company must be notified of any changes to the Plan. This notice must be in writing and provided to the Company at least thirty-one (31) days prior to the effective date of the change. The Company must accept the change in writing before coverage affected by this change will be provided by this Policy. If the Company does not receive advance written notice of the change, or the Company declines coverage of the changes under this Policy, the Company will be liable only for benefits provided by the Plan prior to the change the Policyholder must provide the Company with a copy of the written Plan and all amendments prior to the time the change becomes effective.

### **Subsidiaries, Affiliated Companies under the Plan**

The Policyholder must notify the Company in the event the Policy acquires a subsidiary or affiliated company that will be included under the Plan. If the Policyholder does acquire a subsidiary or affiliated company that will be included under the Plan, the Policyholder must disclose certain required health history on persons whose coverage the Policyholder will be assuming under the Plan. Failure to do so will subject benefits under this Policy to certain limitations, as described in "Disclosure" in Section VI.

Acquisition of a subsidiary of affiliated company that will be included under the Plan may affect the Policyholder's premium rates and or Monthly Aggregate Factors, as described in "Changes in Premium Rates or Factors," in Section VIII.

The Policyholder must notify the Company in the event the Policy cedes or dissolves a subsidiary or affiliate company that was included under the Plan. Failure to do so may subject this Policy to termination (if Minimum Plan Enrollment is not maintained), or may affect premium rates and/or Monthly Aggregate Factors, as describes in "Changes in Premium Rates and Factors," in Section VIII.

### **Duties and Responsibilities of the Policyholder's Designated Claims Administrator/Third Party Administrator (TPA)**

The Claims Administrator or Third Party Administrator must be approved by the Company.

The Company agrees to recognize the Policyholder's Claims Administrator/TPA as the Policyholder's agent for the administration of the Plan. The Policyholder agrees that the Claims Administrator/TPA will:

1. audit, calculate and pay all claims eligible under the Plan;
2. prepare reports required by the Company and keep and make available to the Company data the Company may require; and
3. do what is necessary for the Policyholder to comply with the terms of this Policy.

If the Policyholder gives the Claims Administration/TPA a Power of Attorney, or revokes a Power of Attorney, neither is binding on the Company until the Company receives it.

The Policyholder will pay the Claims Administration/TPA for all administrative functions performed in relation to this Policy.

The Claims Administrator/TPA is the Policyholder's agent and not the Company's. The Policyholder authorizes the Claims Administrator/TPA to:

1. submit Notice/Proof of Loss;
2. certify the Payment of claims;
3. transmit reports and payment of premiums to the Company; and

4. receive payments from the Company.

Payments by the Company to the Claims Administrator/TPA are payment to the Policyholder.

### **Notice**

For the purpose of any notice required from the Company under the terms of this Policy, notice to the Claims Administrator/TPA is notice to the Policyholder and notice to the Policyholder is notice to the Claims Administrator/TPA.

### **Disclaimer**

The Company acts only as a provider of Excess Loss Insurance coverage to the Plan. The Company is not a fiduciary. The Company does not assume any duty to perform any of the functions or provide any of the reports required by the Employee Retirement Income Security Act of 1974, as amended.

The Company has no right or obligation to pay any covered Person or provider of professional or medical services. The Company's sole liability is to the Policyholder, subject to the terms and conditions of this Policy. Nothing in the Policy shall be construed to permit a Covered Person to have a direct right of action against the Company. The Company will not be considered a party to the Policyholder's Plan or to any supplement or amendment to it.

### **Indemnification, Defense and Hold Harmless**

The Policyholder agrees to indemnify, defend and hold the Company harmless from:

1. any liability related to any negligence, error, omission or defalcation by the Claims Administrator/TPA;
2. any liability related to:
  - a. any dispute involving a covered Person unless it is a result of the Company's sole negligence or intentional wrongful acts; and
  - b. any State premium taxes the Company is assessed with respect to funds paid by or to the Policyholder under the Plan. Taxes on amounts paid to the Company as premiums for this Policy are excluded.

The Company will notify the Policyholder if the Policyholder has obligations. The Company may participate in the defense at the Company's expense. If the Policyholder does not act promptly, the Company may defend and compromise or settle the claim or other matter on the Policyholder's behalf, for the Policyholders account, and at the Policyholder's risk.

### **Offset**

The Company may offset payment due the Policyholder under this Policy against claim overpayments and premium due and unpaid.

### **Assignment**

The Policyholder may not assign any of their rights under this Policy.

### **Severability**

Any clause deemed void, voidable, invalid, or otherwise unenforceable, whether or not such a provision is contrary to public policy, will not render any of the remaining provisions of this Policy invalid.

## **Insolvency**

The insolvency, bankruptcy, financial impairment, receivership, voluntary plan or arrangement with creditors, or dissolution of the Policyholder or Claims Administrator/TPA:

1. will not impose upon the Company any liability or additional duties other than those defined and provided for in this Policy (For example, the Company will have no responsibility to pay claims for the Plan to ensure reimbursement under this Policy.) and
2. will not make the Company liable to the Policyholder's creditors, including Covered Persons.

Claims under the Plan must continue to be funded and Paid within contractual time frames in order to be eligible for reimbursement under this Policy.

## **Parties to this Policy**

The Policyholder and the Company are the only parties to this Policy. The Company's sole liability under this Policy is to the Policyholder. This Policy does not create any right or legal relation between the Company and a Covered Person under the Plan. This Policy will not make the Company a party to any agreement between the Policyholder and the Claims Administrator/TPA.

## **Legal Action**

No action at law or in equity shall be brought to recover on this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

## **Time Limit on Certain Defenses**

In the absence of fraud, all statements made by the Policyholder or the Claims Administrator/TPA shall be deemed representations and not warranties. If these statements appear a part of the written Application or other written instrument signed by the Policyholder or Claims Administrator/TPA, the Company may use them to contest the Policy. If the Company does, the Company will furnish the Policyholder or Claims Administrator/TPA with a copy of the document in questions. After two (2) years, only fraudulent misstatements may be used to contest the contract coverage under this Policy.

## **Arbitration**

Any controversy or claim arising out of or relating to this Policy, or the breach hereof, shall be settled by Arbitration in accordance with the rules of the American Arbitration Association, with the express stipulation that the arbitrator(s) shall strictly abide by the terms of this Policy and shall strictly apply rules of law applicable thereto. All matters shall be decided by a panel of three (3) arbitrators. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction. This provision shall survive the termination or expiration of this Policy. The parties hereto may alter any of the terms of this provision only by express written agreement, although such alteration may be before or after any rights or obligations arise under this provision.

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**APPLICATION FOR EXCESS LOSS POLICY**

1. **Full legal name of Policyholder:**  
[ABC Company] \_\_\_\_\_  
(as it will appear in the Policy)
2. **Principal Office Address:**  
[345 Broad St., Anytown, USA] \_\_\_\_\_  
(street) (city) (state) (zip)
3. **Contact Person:** [James Doe] \_\_\_\_\_
4. **Nature of Business:**  
[Consulting] \_\_\_\_\_
5. **Applicant's Federal Tax ID#:** [12-345678] \_\_\_\_\_
6. **If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:**  
[N/A] \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. **Full name of the Employee Welfare Benefit Plan:**  
[N/A] \_\_\_\_\_
- A copy of the Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application. If the Employee Welfare Benefit Plan is for a MEWA (Multiple Employer Welfare Agreement or an MET (Multiple Employer Trust), your application will not be accepted for consideration unless you provide a clear and concise statement from the U. S. Department of Labor that it is exempt from ERISA requirements.
8. **Requested Effective Date:**  
[05.01.09] \_\_\_\_\_
9. **Requested Endorsements:** [AH-30006] \_\_\_\_\_
10. **SILC's Underwriting Manager:** [Jane Doe] \_\_\_\_\_
11. **Designated Claims Administrator/Third Party Administrator:**  
Name: [XYZ Administrative Services, Inc.] \_\_\_\_\_  
Address: [789 Main St.] \_\_\_\_\_  
City, State, Zip: [Anytown, USA] \_\_\_\_\_  
Telephone, Fax, E-mail: [987.654.3210] \_\_\_\_\_  
Website: [www.admin.com] \_\_\_\_\_

- 12. **PPO Vendor:** [DEF Organization]
- 13. **Medical/Large Case Manager:** [Julie Johnson]
- 14. **Utilization Review Vendor:** [XYZ Organization]
- 15. **Other Vendors:** [N/A]
- 16. **Broker/Agent of Record:** [Tom Jones]  
 Address: [456 Hamilton St.]  
 City, State, Zip: [Anywhere, USA]  
 Telephone, Fax, E-mail: [345.678.9100]  
 Website: [www.jones.com]

**17. Coverages Requested**

The Coverage shown applies only during the Policy Period from [05.01.09] (Effective Date) through [04.30.10] (Expiration Date) and is further subject to all the provisions of the Policy.

**SPECIFIC EXCESS LOSS COVERAGE**  Yes, included  No, not included

Coverage to be included:

- | Yes                                 | No                                  |  |
|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | Medical excluding all Prescription Drugs   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Medical including Prescription Drugs defined as <b>one</b> of the following:   |
|                                     |                                     | <input type="checkbox"/> Rx Card & Mail Order <input type="checkbox"/> Rx Card Only <input type="checkbox"/> Rx Mail Order Only or |
|                                     |                                     | <input type="checkbox"/> Rx as part of the Medical Plan subject to a deductible and coinsurance                                    |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Dental   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Vision   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Other: _____   |

**Specific Attachment Point** (unless adjusted by Endorsement)

\$ [xxx,xxx]  Covered Person  Covered Family

Aggregating Specific Deductible: \$ [xx,xxx]

[Does the Aggregating Specific Deductible apply toward the Aggregate Attachment Point?  
 Yes  No]

**Specific Reimbursement Percentage:**

[(Only one of the four options should appear on the Application for Excess Loss Policy)]

[ [100] % of Covered Expenses in excess of the Specific Attachment Point]

[ \_\_\_\_\_ % of the first \$ \_\_\_\_\_ of Covered Expenses in excess of the Specific Attachment Point; and \_\_\_\_\_ % thereafter]

[ \_\_\_\_\_ % of Covered Expenses in excess of the Specific Attachment Point that are incurred at the Policyholder's medical facility or any affiliated or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_ % of all other Covered Expenses in excess of the Specific Attachment Point.]

[ \_\_\_\_\_ % of Covered Expenses that are incurred at the Policyholder's medical facility or

any affiliate or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_% of all other Covered Expenses will apply toward the Specific Attachment Point.]

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

**Specific Lifetime Maximum Reimbursement**

\$ [900,000]  Covered Person  Covered Family

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from [05.01.09] through [04.30.10]  
And Paid from [05.01.09] through [04.30.10]

**If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination.**

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:

\$ [xxxx] per  Covered Person  Covered Family  
 \$ \_\_\_\_\_ for all Covered Persons combined

Plan Benefits Paid after the Expiration Date (Run-Out-Period) will be limited to:

\$ [xxxx] per  Covered Person  Covered Family  
 \$ \_\_\_\_\_ for all Covered Persons combined

**Specific Monthly Premium Rates** – Specific Advance  Yes, included  No, not included  
(Only applicable Units should appear on the Application)

<b>Covered Unit</b>	<b>Premium Rate</b>
Single (Employee only)	\$ <u>[xx]</u>
Employee & Spouse	\$ _____
Employee & Child/ren	\$ _____
Family (Employee/Spouse/Child/ren)	\$ <u>[xx]</u>
Dependent Unit (Spouse/Child/ren)	\$ _____
Composite	\$ _____

Minimum Annual Specific Premium: \$ [xxxx]

**Specific Terminal Liability Option**  Yes, elected  No, not elected

Terminal Run-Out Period: \_\_\_\_\_ months  
(Only applicable Units should appear on the Application)

<b>Covered Unit</b>	<b>Premium Rate</b>
Single (Employee only)	\$ _____
Employee & Spouse	\$ _____
Employee & Child/ren	\$ _____
Family (Employee/Spouse/Child/ren)	\$ _____
Dependent Unit (Spouse/Child/ren)	\$ _____
Composite	\$ _____

**AGGREGATE EXCESS LOSS COVERAGE**  Yes, included  No, not included

Coverage to be included:

**Yes**  **No**  Medical excluding all Prescription Drugs

- Medical including Prescription Drugs defined as **one** of the following:  
 Rx Card & Mail Order    Rx Card Only    Rx Mail Order Only or  
 Rx as part of the Medical Plan subject to a deductible and coinsurance  
  Dental  
  Vision  
  Weekly Disability Income: Maximum \$\_\_\_\_\_ per covered employee per Policy Period  
  Other: \_\_\_\_\_

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

**Monthly Aggregate Factors:** (Only applicable Units should appear on the Application)

Covered Unit	# Units	Medical	Dental	Vision	Rx	WI	Total
Single (Employee only)	[xxx]	[\$xxx]	[\$N/A]	[\$N/A]	[\$N/A]	[\$N/A]	\$ [xxx]
Employee & Spouse		\$	\$	\$	\$	\$	\$
Employee & Child/ren		\$	\$	\$	\$	\$	\$
Family (Employee/Spouse/Children)		\$	\$	\$	\$	\$	\$
Dependent Unit (Spouse/Child/ren)		\$	\$	\$	\$	NA	\$
Composite		\$	\$	\$	\$	\$	\$
						Total	\$

**Minimum Annual Aggregate Attachment Point:** \$ [xxxxx] \_\_\_\_\_  
 (Total Units multiplied by Total Monthly Aggregate Factor times # [xx] months = MAP)

**Aggregate Reimbursement Percentage**

[(Only one of the four options should appear on the Application for Excess Loss Coverage)]

[ [100] \_\_\_\_\_% of Covered Expenses in excess of the Aggregate Attachment Point]

[ \_\_\_\_\_% of the first \$ \_\_\_\_\_ of Covered Expenses in excess of the Aggregate Attachment Point; and \_\_\_\_\_% thereafter]

[ \_\_\_\_\_% of Covered Expenses in excess of the Aggregate Attachment Point that are incurred at the Policyholder's medical facility or any affiliated or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_% of all other Covered Expenses in excess of the Aggregate Attachment Point.]

[ \_\_\_\_\_% of Covered Expenses that are incurred at the Policyholder's medical facility or any affiliate or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_% of all other Covered Expenses will apply toward the Specific Attachment Point.]

**Claim Limit** \$ [xxxxxx] \_\_\_\_\_  Covered Person    Covered Family:

**Maximum Aggregate Reimbursement (per Policy Period):** \$ [100,000] \_\_\_\_\_

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from [05.01.09] \_\_\_\_\_ through [04.30.10] \_\_\_\_\_  
 And Paid from [05.01.09] \_\_\_\_\_ through [04.30.10] \_\_\_\_\_

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:

\$ [xxxx] per  Covered Person  Covered Family  
 \$ \_\_\_\_\_ for all Covered Persons combined

Plan Benefits Paid after the Expiration Date (Run-Out-Period) will be limited to:

\$ [xxxx] per  Covered Person  Covered Family  
 \$ \_\_\_\_\_ for all Covered Persons combined

**Aggregate Excess Loss Premium:** \$ [xxxxx]

Annually in advance  per employee per month \$ \_\_\_\_\_  Monthly \$ \_\_\_\_\_

Applicant's Initials

**If this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and premium paid will not be refundable.**

**Monthly Aggregate Accommodation Option**  Yes, elected  No, not elected

**Monthly Aggregate Accommodation Premium:** \$ \_\_\_\_\_

Annually in advance  per employee per month \$ \_\_\_\_\_  Monthly \$ \_\_\_\_\_

**Aggregate Excess Loss Terminal Liability Option**  Yes, elected  No, not elected

Terminal Run-Out Period: \_\_\_\_\_ months

**Monthly Terminal Factors:** (Only applicable Units should appear on the Application)

Covered Unit	# Units	Medical	Dental	Vision	Rx	WI	Total
Single (Employee only)		\$	\$	\$	\$	\$	\$
Employee & Spouse		\$	\$	\$	\$	\$	\$
Employee & Child/ren		\$	\$	\$	\$	\$	\$
Family (Employee/Spouse/Children)		\$	\$	\$	\$	\$	\$
Dependent Unit Spouse/Child/ren)						NA	\$
Composite		\$	\$	\$	\$	\$	\$
						Total	\$

Annually in advance  per employee per month \$ \_\_\_\_\_  Monthly \$ \_\_\_\_\_

**18. ELIGIBLE FOR COVERAGE**

**Eligible for Coverage** Yes\* No

Disabled Persons

COBRA Beneficiaries

Retired Employees, if yes:  Specific coverage only  
 Specific & Aggregate Coverages, or  
 Aggregate coverage only

Employees who are not Actively at Work

Transplants

**\*All "Yes" answers must have disclosure information attached to this Application**

19. Special Limitations: Specific: [N/A] Aggregate: [N/A]

20. Initial premium deposit accompanying the application: \$ [xxxxx]

21. Minimum Plan Enrollment: [xxx] Covered Units, or [xx] % of initial enrollment

**You, the applicant, have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by the company and as reflected in the Application. You, the applicant, represent that you have formed your Employee Welfare Benefits Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable law or regulation. It is agreed that the statements in the Application or in any materials submitted with this Application or attached to it are your representations and shall be deemed material to acceptance or the risk by the Company and that the Policy is issued by the Company in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage hereunder, the Company will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to you, the applicant/Policyholder. Any fraudulent statement will render the Policy null and void and claims, if any, will be forfeited.**

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

**This Application does not bind Coverage.** Upon approval of the application, the Policy evidencing that the coverage is in force will be issued by the Company through the Company's Underwriting Manager. Coverage will commence on the Effective Date set forth in the Policy. This application will attach to and form part of the Policy.

**NOTICE:** Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and/or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employers/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded health plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

**Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

**ACCEPTED BY THE POLICYHOLDER:**

Signed at: \_\_\_\_\_

[ABC Company]  
(Policyholder - correct legal name)

Date: [Date] \_\_\_\_\_

[James Doe]  
(Officer's Name)

[President]  
(Title)

[Tom Jones]  
(Policyholder's Broker/Agent of Record)

**ACCEPTED BY THE COMPANY:**

Signed at: \_\_\_\_\_

[SILC]  
(On behalf of the Company)

Date: [Date] \_\_\_\_\_

[June Roe]  
(By (Officer's Name))

[Secretary]  
(Title)

**STATE-SPECIFIC REQUIRED FRAUD WARNINGS**

**Arkansas, Louisiana and West Virginia Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss of benefits 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.

**California, Ohio and Pennsylvania Residents:** Any person who knowingly presents a false or fraudulent claim of 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 civil fines and confinement in state prison.

**Colorado Residents:** 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.

**District of Columbia Residents:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Florida Residents:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceived any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Kentucky Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

**Maine and Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**Missouri Residents:** An insurance company or its agent or representative may not ask an applicant or policyholder to divulge in a written application or otherwise whether any insurer has canceled or refused to renew or issue to the applicant or policyholder a policy of insurance. If a question(s) appears in this application, you should not answer it.

**New Jersey Residents:** Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**North Carolina Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

**Ohio Residents:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Oregon Residents:** Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

**Vermont Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

**Virginia Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which may be a crime and subjects such person to criminal and civil penalties.

**Washington Residents:** 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.

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**SCHEDULE OF EXCESS LOSS COVERAGE**

**Policy Number:** [12345]

**Policyholder:**

[ABC Company]

(As it will appear in the Policy)

Principal Office Address:

[345 Broad St., Anytown, USA]

(Street)

(City)

(State)

(Zip)

Subsidiary or affiliated companies to be included (list legal names and addresses):

[N/A]

**Effective Date:** [05.01.09]

**Expiration Date:** [04.30.10]

**Premium Due Date:** Premium is due on the Effective Date of Coverage and the first of each month beginning with [Month, Day, and Year].

**Enrollment** (at the beginning of the Policy Period) (Only applicable Units should appear on the Schedule)

**Covered Unit**

**# Covered Units**

Single (Employee only)

[xxx]

Employee & Spouse

Employee & Child/ren

Family (Employee/Spouse/Children)

Composite

Employee

Dependent Unit

Minimum Plan Enrollment: [xxxx]

**Claims Administrator(s)/Third Party Administrator(s):**

[XYZ Administrative Services, Inc.]

Address:

[789 Main St., Anytown, USA]

(Street)

(City)

(State)

(Zip)

Phone: [987.654.3210]

Fax: [876.543.2100]

E-mail: xyz@services.com

**COVERAGE**

The Coverage shown applies only during the Policy Period and is further subject to all the provisions of the Policy.

Actively at Work/Disability requirement

Applicable

Waived with approved disclosure

(Policyholder's Initials)

Eligible for Coverage	Yes	No	
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Disabled Persons
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	COBRA Beneficiaries
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Retired Employees, if yes: <input type="checkbox"/> Specific coverage only
			<input type="checkbox"/> Specific & Aggregate coverages <input type="checkbox"/> Aggregate coverage only
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Employees who are not Actively at Work
	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Transplants

**SPECIFIC EXCESS LOSS COVERAGE**       Yes, included       No, not included

Coverage to be included:

Yes	No	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Medical excluding all Prescription Drugs
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Medical including Prescription Drugs defined as <b>one</b> of the following:
		<input type="checkbox"/> Rx Card & Mail Order <input type="checkbox"/> Rx Card Only <input type="checkbox"/> Rx Mail Order Only or
		<input type="checkbox"/> Rx as part of the Medical Plan subject to a deductible and coinsurance
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Dental
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Vision
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Other: _____

**Specific Attachment Point**

\$ \_[xxx,xxx]\_\_\_\_\_       Covered Person       Covered Family

Aggregating Specific Deductible: \$ \_[xx,xxx]\_\_\_\_\_

Does the Aggregating Specific Deductible apply toward the Aggregate Attachment Point:  Yes     No

**Specific Reimbursement Percentage:**

[(Only one of the four options should appear on the Schedule of Excess Loss Coverage)]

\_[100]\_\_\_\_\_ % of Covered Expenses in excess of the Specific Attachment Point]

\_\_\_\_\_ % of the first \$ \_\_\_\_\_ of Covered Expenses in excess of the Specific Attachment Point; and \_\_\_\_\_ % thereafter]

\_\_\_\_\_ % of Covered Expenses in excess of the Specific Attachment Point that are incurred at the Policyholder's medical facility or any affiliated or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_ % of all other Covered Expenses in excess of the Specific Attachment Point.]

\_\_\_\_\_ % of Covered Expenses that are incurred at the Policyholder's medical facility or any affiliate or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_ % of all other Covered Expenses will apply toward the Specific Attachment Point.]

**Specific Lifetime Maximum Reimbursement** \$ \_[900,000]\_\_\_\_\_     Covered Person     Covered Family

Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from \_[05.01.09]\_\_\_\_\_ through \_[04.30.10]\_\_\_\_\_  
 And Paid from \_[05.01.09]\_\_\_\_\_ through \_[04.30.10]\_\_\_\_\_

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:

\$ \_[xxxx]\_\_\_\_\_     Covered Person       Covered Family

\$ \_\_\_\_\_ for all Covered Persons combined

Plan Benefits Paid after the Expiration Date (Run-Out-Period) will be limited to:

\$ [xxxx]  Covered Person  Covered Family

\$ \_\_\_\_\_ for all Covered Persons combined

**If this Policy terminates prior to the Expiration Date, the Benefit Period will not extend past the date of termination.**

**Specific Monthly Premium Rates** – Specific Advance  Yes, included  No, not included  
(Only applicable Units should appear on the Schedule)

Covered Unit	# Covered Units	Premium Rate
Single (Employee only)	[x]	\$ [xx]
Employee & Spouse		\$
Employee & Child/ren		\$
Family (Employee/Spouse/Child/ren)	[x]	\$ [xx]
Dependent Unit (Spouse/Child/ren)		\$
Composite		\$

Minimum Annual Specific Premium: \$ [xxxx]

**Specific Terminal Liability Option**  Yes, elected  No, not elected

Terminal Run-Out Period: \_\_\_\_\_ months  
(Only applicable Units should appear on the Schedule)

Covered Unit	# Covered Units	Premium Rate
Single (Employee only)		\$
Employee & Spouse		\$
Employee & Child/ren		\$
Family (Employee/Spouse/Child/ren)		\$
Dependent Unit (Spouse/Child/ren)		\$
Composite		\$

**AGGREGATE EXCESS LOSS COVERAGE**  Yes, included  No, not included

Coverage to be included:

- | Yes                                 | No                                  |  |
|-------------------------------------|-------------------------------------|--|
| <input checked="" type="checkbox"/> | <input type="checkbox"/>            | Medical excluding all Prescription Drugs   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Medical including Prescription Drugs defined as <b>one</b> of the following:   |
|                                     |                                     | <input type="checkbox"/> Rx Card & Mail Order <input type="checkbox"/> Rx Card Only <input type="checkbox"/> Rx Mail Order Only or |
|                                     |                                     | <input type="checkbox"/> Rx as part of the Medical Plan subject to a deductible and coinsurance                                    |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Dental   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Vision   |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Weekly Disability Income: Maximum \$ _____ per covered employee per Policy Period  |
| <input type="checkbox"/>            | <input checked="" type="checkbox"/> | Other: _____   |

Monthly Aggregate Factors: (Only applicable Units should appear on the Schedule)

Covered Unit	# Units	Medical	Dental	Vision	Rx	WI	Total
Single (Employee only)	[xxx]	[\$xxx]	[\$N/A]	[\$N/A]	[\$N/A]	[\$N/A]	[\$xxx]
Employee & Spouse		\$	\$	\$	\$	\$	\$
Employee & Child/ren		\$	\$	\$	\$	\$	\$
Family (Employee/Spouse/Child/ren)		\$	\$	\$	\$	\$	\$
Dependent Unit (Spouse/Child/ren)		\$	\$	\$	\$	NA	\$
Composite		\$	\$	\$	\$	\$	\$
Total						Total	\$

Minimum Annual Aggregate Attachment Point: \$ [xxxxx] (Total Units multiplied by Total Monthly Aggregate Factor times # [xx] months = MAP)

Aggregate Reimbursement Percentage

[(Only one of the four options should appear on the Schedule of Excess Loss Coverage)]

[ [100] % of Covered Expenses in excess of the Aggregate Attachment Point]

[ \_\_\_\_\_% of the first \$ \_\_\_\_\_ of Covered Expenses in excess of the Aggregate Attachment Point; and \_\_\_\_\_% thereafter]

[ \_\_\_\_\_% of Covered Expenses in excess of the Aggregate Attachment Point that are incurred at the Policyholder's medical facility or any affiliated or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_% of all other Covered Expenses in excess of the Aggregate Attachment Point.]

[ \_\_\_\_\_% of Covered Expenses that are incurred at the Policyholder's medical facility or any affiliate or subsidiary medical facilities of the Policyholder, (attach a list of the names of all affected facilities and providers); and \_\_\_\_\_% of all other Covered Expenses will apply toward the Specific Attachment Point.]

Claim Limit \$ [xxxxxx] [x] Covered Person [ ] Covered Family

Maximum Aggregate Reimbursement (per Policy Period): \$ [100,000]

Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from [05.01.09] through [04.30.10] And Paid from [05.01.09] through [04.30.10]

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:

- \$ [xxxx] [x] Covered Person [ ] Covered Family
- \$ \_\_\_\_\_ for all Covered Persons combined

Plan Benefits Paid after the Expiration Date (Run-Out-Period) will be limited to:

- \$ [xxxx] [x] Covered Person [ ] Covered Family
- \$ \_\_\_\_\_ for all Covered Persons combined

(Policyholder's Initials)

Aggregate Excess Loss Premium: \$ [xxxxx]

Annually in advance per employee per month \$ Monthly \$

If this Policy terminates prior to the Expiration Date, no Aggregate Excess Loss Benefits will be payable and premium paid will not be refundable.

Monthly Aggregate Accommodation Option Yes, elected No, not elected

Monthly Aggregate Accommodation Premium: \$

Annually in advance per employee per month \$ Monthly \$

Aggregate Excess Loss Terminal Liability Option Yes, elected No, not elected

Terminal Run-Out Period: months

Monthly Terminal Factors: (Only applicable Units should appear on the Schedule)

Table with 8 columns: Covered Unit, # Units, Medical, Dental, Vision, Rx, WI, Total. Rows include Single (Employee only), Employee & Spouse, Employee & Child/ren, Family (Employee/Spouse/Children), Dependent Unit (Spouse/Child/ren), Composite, and Total.

Aggregate Excess Loss Terminal Liability Premium: \$

Annually in advance per employee per month \$ Monthly \$

Special Limitations: Yes, included No, not included

Specific Limitations

Aggregate Limitations

Endorsements Included:

- Specific Advance Option
Aggregating Specific Deductible
Rate Stabilization
Aggregate Quota Share
Individuals Excluded
Specific Terminal Liability Option
Aggregate Terminal Liability Option
Monthly Aggregate Accommodation

(Policyholder's Initials)

**[Additional Information]**

**STARR INDEMNITY & LIABILITY COMPANY**

**Administrative Office:**

**[90 Park Avenue**

**7<sup>th</sup> Floor**

**New York, NY 10016]**

**POLICYHOLDER ACCEPTANCE**

**Policy Number:**     [12345]    

**Policyholder:**     [ABC Company]      
(Legal Name)

has received a Starr Indemnity & Liability Company (SILC) Policy #     [12345]      
and has approved and accepted the terms of this Policy.

**No reimbursement under this Policy will be paid until such time as this Policyholder Acceptance has been executed and received by SILC.**

Any person who knowingly, with intent to injure, defraud or deceive any insurer, submits application or makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

**Name:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
(Please Print Name of Signatory) (Please Print)

**By:** \_\_\_\_\_  
(Signature of Policyholder)

**Signed at:** \_\_\_\_\_ **On:** \_\_\_\_\_  
(City/State) (Date)

**Witness:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
(Signature) (Please Print)

**Instructions to Policyholder:**

- (1) Sign and return to SILC**
- (2) Retain a copy with your Policy**

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**AGGREGATING SPECIFIC DEDUCTIBLE ENDORSEMENT**

This Endorsement modifies coverage provided under the following:

**SCHEDULE OF EXCESS LOSS COVERAGE**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

**Aggregating Specific Deductible**

The Policyholder and the Company agree to the addition of the following provision:

**Aggregating Specific Deductible**

[ \$ [xx,xxx] ]

[The greater of \$ [xxxx] or \$ [xx] per covered unit per month. Reconciliation to determine the actual Aggregating Specific Deductible will be preformed at the end of the Policy Year.]

No amounts will be payable to the Policyholder under the Excess Loss Policy until the Aggregating Specific Deductible has been satisfied.

Aggregating Specific Deductible means an aggregate amount, in excess of and in addition to the Specific Attachment Point for each Covered Person, which the Policyholder must also incur during the Policy Period before the Company will reimburse the Policyholder for Plan Benefits Paid.

Amounts accumulated toward the Aggregating Specific Deductible are [not] covered under Aggregate coverage.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:

  
[Richard N. Shaak], President

  
[Honora M. Keane], General Counsel

Endorsement Number: [AH-30006]

Effective Date: [05.01.09]

Policy Number: [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

Starr Indemnity & Liability Company  
Administrative Office:  
[90 Park Avenue  
7<sup>th</sup> Floor  
New York, NY 10016]

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**SPECIFIC TERMINAL LIABILITY ENDORSEMENT**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

The Company will extend the payment period for Specific Excess Loss coverage for three (3) months beyond the Expiration Date if the Policyholder:

1. terminates the Plan on the Expiration Date of this Policy; and
2. furnish the Company acceptable proof that the Policyholder purchased conventional group insurance coverage that immediately replaces the terminated Plan.

Only those Plan Benefits Incurred during the Policy Period and prior to the Expiration Date will be considered under Specific Excess Loss Coverage.

This Endorsement does not apply to Aggregate Excess Loss Coverage.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

Endorsement Number: [AH-30008]

Effective Date: [05.01.09]

Policy Number: [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**AGGREGATE ACCOMMODATION ENDORSEMENT**

This Endorsement modifies coverage provided under the following:

**SCHEDULE OF EXCESS LOSS COVERAGE**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

**Monthly Aggregate Benefit**

An Aggregate Accommodation will be provided if:

1. in any month during the policy period the total plan benefits paid by the Policyholder, for which reimbursement is provided under the terms of the Employer Stop Loss Policy, exceed the sum of:
  - the greater of:
    - the cumulative Annual Aggregate Attachment Point; or
    - the cumulative pro rata share of the Minimum Annual Aggregate Point; and
  - any previous aggregate accommodation payments; and
  - **[\$5,000]**
2. the claims were properly Paid as described in the Policy; and
3. the claims reporting criteria as described in the Employer Stop Loss Policy has been met; and
4. premiums for coverage under the Employer Stop Loss Policy are paid up-to-date; and
5. the Aggregate Accommodation request is made within **[fifteen (15)]** days following the end of the month, by submitting to the Company a completed Monthly Aggregate Reimbursement Claim Form along with the required reports.

The Aggregate Accommodation will be the sum of amounts paid by the Plan that exceed the sums of the calculated Aggregate Attachment Point, and any amounts previously paid as an Aggregate Accommodation.

The Aggregate Accommodation is not available:

1. during the first **[ninety (90)]** days following the Policy's Effective Date; or
2. during the last month of the Policy Period, or during the Run-Out-Period; or
3. if the Policy is terminated prior to the Expiration Date.

**Reconciliation/Reimbursement of Aggregate Accommodation**

Reimbursement is due when:

1. if during any month, the accumulated Annual Aggregate Attachment Point is greater than the accumulated eligible paid claims plus any paid Aggregate Accommodation amounts, repayment is due within thirty (30) days of written notice; or

2. at the end of the Policy Period, or if coverage terminates before the end of the Policy Period, after the completion of an audit review of all required reports, if the Aggregate Attachment Point is greater than the eligible paid claims plus any paid Aggregate Accommodation amounts, repayment is due within thirty (30) days of written notice.
3. coverage terminates prior to the Expiration Date, the Aggregate Accommodation Endorsement becomes null and void, and repayment of any Aggregate Accommodation payments made by the Company is due within thirty (30) day of the termination date, and premium paid will not be refundable.

Interest will not be charged on the amount of any Aggregate Accommodation, however, if you do not repay any outstanding Aggregate Accommodation within the time frames stated in this Endorsement then:

1. a late penalty equal to [15%] of the overpayment amount will be applied; and
2. any subsequent reimbursements due under the aggregate or specific excess loss benefits will be reduced by the amount of the overpayment.

**Treatment of Accommodation**

The accommodation provided under this Endorsement shall be an obligation of the Policyholder for which no interest shall be charged and shall be repaid as provided herein. The accommodation is neither a loan nor an advance on any payments to be made pursuant to the Policy. Any accommodation shall at all times be considered funds of the Company for which the use by the Policyholder of such funds is provided in this Endorsement. The Company shall have preference over all other claimants for the return of an accommodation made under this Endorsement. The Policyholder shall be liable for all costs and expenses, including reasonable attorney’s fees, incurred in the collection of any amount of accommodation outstanding.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:

  
 [Richard N. Shaak], President

  
 [Honora M. Keane], General Counsel

Endorsement Number:   [AH-30009]  

Effective Date:   [05.01.09]  

Policy Number:   [12345]  

Policyholder Name:   [ABC Company]  

Signature of Policyholder’s Authorized Representative: \_\_\_\_\_

Print Name:   [James Doe]   Title:   [President]  

(Please Print)

Date Signed:   [Date]

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**AGGREGATE EXCESS LOSS TERMINAL LIABILITY ENDORSEMENT**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

The Policyholder and Company agree to the following provision:

This Endorsement is applicable only if the following conditions exist:

1. The Policy to which this Endorsement is attached does not provide for payment of Aggregate Excess Loss Coverage for claims Paid beyond the Expiration Date of the Policy.
2. In the event the Policy to which this Endorsement is attached is the Policyholder's first policy, contract or agreement providing aggregate excess loss coverage;
  - a. this Endorsement must be attached and made effective the same date as the Policy Effective Date; and
  - b. the Policy does not provide for payment of claims incurred prior to the effective Date of the Policy.
3. In the event the Policy to which this Endorsement is attached is subsequent to another Excess Loss policy, contract or agreement, issued by the Company [or anyone else], all such previous Excess Loss Policies must have had this same or similar Endorsement attached thereto.

This Endorsement applies on to Aggregate Excess Loss Coverage and does not change or alter any coverage under the Specific Excess Loss coverage provided by the Policy.

If, at the Expiration Date of the Policy, the Policy terminates the Plan and replaces it with a fully-insured conventional group health benefit plan, the Company will extend the Aggregate Excess Loss coverage provided by the Policy during the Terminal Extension Period, provided:

1. such fully-insured conventional group health benefit plan immediately replaces the Policyholder's Plan, thereby eliminating any gap in coverage for the Plan's beneficiaries;
2. such fully-insured conventional group health benefit plan provides benefits substantially similar to the benefits provided by the Plan;
3. the Policyholder provides proof acceptable to the Company of such replacement; and
4. the Policy Period does not continue past the Expiration Date of the Policy.

If the Policyholder's net Paid claims for the Policy Period plus the Terminal Extension Period exceed the Terminal Liability Extension Aggregate Reimbursement, the Company will pay such excess amount to the Policyholder. Net Paid claims are based on claim incurred prior to the Plan's termination date, less any claims reimbursed under the specific Excess Loss coverage.

Any Aggregate Excess Loss benefit due under this Endorsement will be delayed until a final determination can be made following the Terminal Extension Period.

The Company will reduce benefits payable under this Endorsement by the amount of benefits paid for the same losses by any other policy, contract or agreement.

The Policyholder will pay a monthly service fee of [\$1.00-3.00 ] per Covered Unit during the period this Endorsement is in effect. This fee is due and payable on or before the first day of each month.

**Terminal Extension Period** means the three (3) consecutive calendar months immediately succeeding the Expiration Date of the Policy.

**Terminal Liability Extension Aggregate Reimbursement** is established by combining the Annual Aggregate Attachment Point for the Policy and the Terminal Extension Period, as follows:

1. Multiply the Terminal Liability Extension Factors by the average of Covered Units for the three-month period immediately preceding the Expiration Date of the Policy and by three (3) months.
2. Add the result of 1. above to the Annual Aggregate Attachment Point or Minimum Annual Aggregate Attachment Point, whichever is greater, that is determined for the Policy Period.

**Terminal Liability Extension Factors** are as follows:

Covered Unit Description:     Single (Employee Only) : [\$1.15-1.25%] of Factor per Covered Unit  
   Employee & Spouse :     [\$1.15-1.25%] of Factor per Covered Unit  
   Employee & Children :     [\$1.15-1.25%] of Factor per Covered Unit  
   Family (Employee/Spouse/Children) [\$1.15-1.25%] of Factor per Covered Unit  
   Dependent Unit (Spouse/Children) [\$1.15-1.25%] of Factor per Covered Unit  
   Composite :     [\$1.15-1.25%] of Factor per Covered Unit

This endorsement does not apply to Specific Excess Loss Coverage.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:

  
 \_\_\_\_\_  
 [Richard N. Shaak], President

  
 \_\_\_\_\_  
 [Honora M. Keane], General Counsel

Endorsement Number:   [AH-30010]  

Effective Date:   [05.01.09]  

Policy Number:   [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**INDIVIDUALS EXCLUDED UNDER EXCESS LOSS COVERAGE ENDORSEMENT**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

[The Policyholder and the Company agree that claims on the following named individual(s) is/are not covered under the Specific Excess Loss Coverage provision of the Policy:] **[John Smith]**

[This exclusion does not apply to Aggregate Excess Loss coverage.]

[The Policyholder and the Company agree that claims on the following named individual(s) is/are not covered under the Aggregate Excess Loss Coverage provision of the Policy:] **[John Smith]**

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

Endorsement Number:   [AH-30011]  

Effective Date:   [05.01.09]  

Policy Number:   [12345]  

Policyholder Name:   [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**RATE STABILIZATION ENDORSEMENT**

This Endorsement modifies coverage provided under the following:

**SCHEDULE OF EXCESS LOSS COVERAGE**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

In consideration of the premium charged, the Policyholder and the Company agree to the addition of the following provision/s:

**[Specific Excess Loss Coverage**

This Endorsement is applicable only if the following conditions exist at renewal:

1. the contract terms remain unchanged;
2. the demographics of the group remain similar;
3. the Plan remains unchanged; and
4. there is less than a [10%] variation in Plan participation.

The Company will guarantee that upon renewal:

1. Specific rates will not increase more than [  30-50   %]; and
2. the Company will not apply any additional lasers, unless requested by the Policyholder.

This Endorsement does not reduce or remove any currently lasered individuals and assumes all current lasers will remain unless specifically removed by the Company.

**[Aggregate Excess Loss Coverage**

This Endorsement is applicable only if the following conditions exist at renewal:

1. the contract terms remain unchanged;
2. the demographics of the group remain similar;
3. the Plan remains unchanged; and
4. there is less than a [10%] variation in Plan participation.

The Company will guarantee that upon renewal:

1. Aggregate rates will not increase more than [  0-20   %]; and

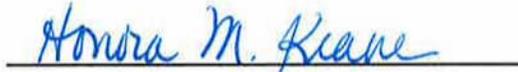
2. Aggregate factors will not increase more than [ 0-20 %].

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

Endorsement Number: [AH-30012]

Effective Date: [05.01.09]

Policy Number: [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

Starr Indemnity & Liability Company  
Administrative Office:  
[90 Park Avenue  
7<sup>th</sup> Floor  
New York, New York 10016]

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**AGGREGATE QUOTA SHARE ENDORSEMENT**

This Endorsement modifies coverage provided under the following:

**SCHEDULE OF EXCESS LOSS COVERAGE**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

**Aggregate Coverage**

The Company will provide a split-funded aggregate option for large group with greater than [200] employees transitioning from a fully-insured environment.

The Minimum Attachment Point will be calculated expected claims plus: [10% -----50%] margin.

The Aggregate Reimbursement Percentage the Company will pay will be: [50%] [75%] [25%]

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

Signed for STARR INDEMNITY & LIABILITY COMPANY by:



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

Endorsement Number: [AH-30013]

Effective Date: [05.01.09]

Policy Number: [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]

(Please Print)

Date Signed: [Date]

**Starr Indemnity & Liability Company  
Administrative Office:  
[90 Park Avenue  
7<sup>th</sup> Floor  
New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

## **SPECIFIC ADVANCE ENDORSEMENT**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

### **SPECIFIC ADVANCE**

A Specific Advance will be provided if:

- The Claim Administrator prior to the expiration of the Employer Stop Loss Policy has processed all eligible expenses relating to this Specific Advance request.
- Checks totaling at least the amount of the Specific Attachment Point have been processed, paid and released to the indicated providers prior to the expiration of the Employer Stop Loss Policy, or prior to the Specific Advance request, whichever is earlier.
- The Claims Administrator has unconditionally paid all other claims for the Claimant.
- Premium has been paid through the month in which the claim is submitted.
- All eligible expenses must be immediately released to providers upon our payment of the claim.
- The claim request must be equal to or greater than **[\$5,000]**.

Written notice of Specific Advance Requests must be received by the Company no more than seven (7) calendar days after the expiration date indicated in the Employer Stop Loss Policy.

**Specific Advance will not be provided if the policy terminates due to early cancellation or premature termination.**

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

**Signed for STARR INDEMNITY & LIABILITY COMPANY by:**



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

Endorsement Number: [AH-30014]

Effective Date: [05.01.09]

Policy Number: [12345]

Policyholder Name: [ABC Company]

Signature of Policyholder's Authorized Representative: \_\_\_\_\_

Print Name: [James Doe] Title: [President]  
(Please Print)

Date Signed: [Date]

**Starr Indemnity & Liability Company**  
**Administrative Office:**  
**[90 Park Avenue**  
**7<sup>th</sup> Floor**  
**New York, NY 10016]**

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**ARKANSAS POLICY ENDORSEMENT**

This Endorsement changes the Policy effective on the Policy Effective Date unless another date is indicated below.

This Endorsement modifies coverage provided under the following:

1. Proof of Loss in **SECTION XI, CLAIM PROVISIONS**, is deleted and replaced with the following:

**Proof of Loss**

Written proof of loss must be submitted within ninety (90) days after the date of loss. Late proof will be accepted only if it is shown to have been furnished as soon as reasonable possible and within one (1) year of the date of loss.

2. Time Limit on Certain Defenses in **SECTION XII, GENERAL PROVISIONS** is deleted and replaced with the following:

**Time Limit on Certain Defenses**

In the absence of fraud, all statements made by the Policyholder or the Claims Administrator/TPA shall be deemed representations and not warranties. If these statements appear a part of the written Application or other written instrument signed by the Policyholder or Claims Administrator/TPA, the Company may use them to contest the Policy. If the Company does, the Company will furnish the Policyholder or Claims Administrator/TPA with a copy of the document in questions. After three (3) years, only fraudulent misstatements may be used to contest the contract coverage under this Policy.

**THERE ARE NO POLICY CHANGES UNDER THIS ENDORSEMENT OTHER THAN THOSE STATED ABOVE.**

**Signed for STARR INDEMNITY & LIABILITY COMPANY by:**



[Richard N. Shaak], President



[Honora M. Keane], General Counsel

**Endorsement Number:** \_\_\_\_\_

**Effective Date:** \_\_\_\_\_

**Policy Number:** \_\_\_\_\_

**Policyholder Name:** \_\_\_\_\_

*SERFF Tracking Number:* MCHX-126070179                      *State:* Arkansas  
*Filing Company:* Starr Indemnity & Liability Company                      *State Tracking Number:* 41768  
*Company Tracking Number:* AH-30001  
*TOI:* H21 Health - Other                      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* AH-30001 Starr Indemnity & Liability Stop Loss  
*Project Name/Number:* AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-126070179 State: Arkansas  
 Filing Company: Starr Indemnity & Liability Company State Tracking Number: 41768  
 Company Tracking Number: AH-30001  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AH-30001 Starr Indemnity & Liability Stop Loss  
 Project Name/Number: AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 03/12/2009  
**Comments:**  
**Attachment:**  
 Readability.PDF

**Satisfied -Name:** Application **Review Status:** Approved-Closed 03/12/2009  
**Comments:**  
 See forms tab

**Bypassed -Name:** Outline of Coverage **Review Status:** Approved-Closed 03/12/2009  
**Bypass Reason:** not applicable to this filing  
**Comments:**

**Satisfied -Name:** Authorization Letter **Review Status:** Approved-Closed 03/12/2009  
**Comments:**  
**Attachment:**  
 Authorization Letter.PDF

**Satisfied -Name:** Cover Letter **Review Status:** Approved-Closed 03/12/2009  
**Comments:**  
**Attachment:**  
 Cover Letter.PDF

**Satisfied -Name:** Form Listing **Review Status:** Approved-Closed 03/12/2009  
**Comments:**  
**Attachment:**

*SERFF Tracking Number:* MCHX-126070179      *State:* Arkansas  
*Filing Company:* Starr Indemnity & Liability Company      *State Tracking Number:* 41768  
*Company Tracking Number:* AH-30001  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* AH-30001 Starr Indemnity & Liability Stop Loss  
*Project Name/Number:* AH-30001 Starr Indemnity & Liability Stop Loss/AH-30001 Starr Indemnity & Liability Stop Loss

**Form Listing.PDF**

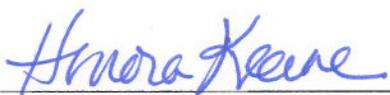


**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME: Starr Indemnity & Liability Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
AH-30001	42
AH-30002-AR	42
AH-30003	42
AH-30005	42
AH-30006	42
AH-30008	42
AH-30009	42
AH-30010	42
AH-30011	42
AH-30012	42
AH-30013	42
AH-30014	42
AH-30001-END-AR	42

Signed:   
Name: Honora M. Keane  
Title: General Counsel  
Date: February 17, 2009

---

Starr Indemnity & Liability Company  
90 Park Avenue, 7<sup>th</sup> Floor  
New York, NY 10016

---

January 13, 2009

NAIC Company Code: 38318

Re: See Attached Forms Listing

Please accept this letter as authorization from Starr Indemnity & Liability Company for McHugh Consulting Resources, Inc. to file any or all policy forms as referenced on the attached form listing on behalf of Starr Indemnity & Liability Company.

Sincerely,



---

Honora M. Keane  
Legal & Compliance Officer  
Starr Indemnity & Liability Company

.....  
**McHugh Consulting Resources, Inc.**

March 11, 2009

**SUBMITTED VIA SERFF**

Jay Bradford  
Insurance Commissioner  
Arkansas Department of Insurance  
Compliance Life and Health  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: **STARR INDEMNITY & LIABILITY COMPANY**  
NAIC No. 38318            FEIN No. 75-1670124  
**Excess Loss Insurance Program**  
AH-30001, et al            Excess Loss Insurance Policy  
Please see attached Forms Listing

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the enclosed forms on behalf of Starr Indemnity & Liability Company. We have provided an authorization letter for your files.

The above referenced forms are submitted for your review and approval. As a matter of information, the forms are new and do not replace any forms previously filed with or approved by your Department.

This excess loss coverage is designed to be offered to employer groups who self fund their employee medical plan. This coverage is purchased by the employer to protect itself from catastrophic losses. Benefits are payable to the employer and not individual employees. While the benefits covered under the plan will parallel the employer's underlying plan, it is not medical coverage for the employees. As excess/stop loss coverage is not "health insurance coverage" as defined under the federal Health Insurance Portability and Accountability Act (HIPAA) it is not subject to the requirements in the HIPAA law. Benefits will be offered on a specific or aggregate basis, or both. The exact benefits will vary depending on the options chosen by the employer. Marketing for this product will be done via licensed agents and brokers.

Printing of all forms is subject to changes in page numbers, margins, positioning and format. Printing standards will never be less than required under your law. Electronic use of this form may result in changes or variations in margins, formatting and pagination. However, the text will not be less than ten-point type and the form will meet the readability standards required under your law.

*Commissioner of Insurance  
Starr Indemnity & Liability Company  
Page 2*

Variable data is bracketed and may vary from case to case. Amounts may vary or provisions may be modified to fit a specific Policyholder's request. Variable data will never exclude or limit provisions required by your state.

Starr Indemnity & Liability Company will deem these forms approved, if upon the expiration of the initial review period, your Department has not extended the review period or otherwise has not responded to this submission

Enclosed please find any required certifications and/or transmittal forms. If you should have any questions or concerns regarding this submission, please do not hesitate to contact us. We thank you in advance for your time and consideration.

Sincerely,

A handwritten signature in cursive script, appearing to read "M. Diane Davis".

M. Diane Davis, FLMI  
Consultant

**STARR INDEMNITY & LIABILITY COMPANY**  
**90 PARK AVENUE**  
**7<sup>TH</sup> FLOOR**  
**NEW YORK, NY 10016**

**Excess Loss Form Numbers**

Form Number	Form Name
AH-30001	Excess Loss Insurance Policy
AH-30002-AR	Application for Excess Loss Policy
AH-30003	Schedule of Excess Loss Coverage
AH-30005	Policyholder Acceptance
AH-30006	Aggregating Specific Deductible Endorsement
AH-30008	Specific Terminal Liability Endorsement
AH-30009	Aggregate Accommodation Endorsement
AH-30010	Aggregate Terminal Liability Endorsement
AH-30011	Individuals Excluded Under Excess Loss Coverage Endorsement
AH-30012	Rate Stabilization Endorsement
AH-30013	Aggregate Quota Share Endorsement
AH-30014	Specific Advance Endorsement
AH-30001-END-AR	Arkansas Policy Endorsement