bardon insurance group, inc.

Dear TPA, Broker or Plan Sponsor,

Thank you for your interest in Bardon as the stop loss coverage vendor for this plan and your time in the gathering the health statements. The information obtained through these forms is extremely important to the underwriting process and the resulting risk profile is an invaluable tool to the employer in making the decision to self fund their health benefits.

It is very important that we make every effort to protect the information provided by the plan participants in these forms.

The following materials are included:

- Instructions for completing the statement of health
- The statement of health (2 pages)
- Disclosure form for employers that are utilizing the statement of health

All enrollee's should be provided with the instructions for completing the statement of health (or similarly worded letter / memo from the employer, broker or TPA), a copy of the statement of health (**both pages**) and an envelope. Set a deadline for the return of the health statements and designate an individual to receive them. The collected health statements may then be returned to the TPA and submitted to Bardon Insurance Group by fax, secured email attachment or by mail. Whichever method is used it is very important that the form be legible should it be necessary for us to forward the authorization to a medical provider for additional information.

HIPAA privacy regulations require that all individuals to be covered that are 18 or older to sign the form. It is also important to note that our form has **two signature areas**. The first is a declaration that the information provided is complete and accurate. The second is the authorization to release medical information.

The attached disclosure form is only for use with employer groups that are utilizing the health statements. It only asks that the employer disclose all individuals not actively at work, COBRA individuals, and those individuals that are COBRA eligible. The disclosure may be dated up to 45 days in advance of the effective date. However, disclosures that are dated greater than 15 days from the effective date must be accompanied by ½ of the first month's premium with remainder to be received by the effective date. The health statements may be completed up to 45 days in advance of the effective date with no premium requirement.

Please emphasize the importance of accuracy and completeness when distributing the forms.

Again, thanks for your time and consideration.

INSTRUCTIONS FOR COMPLETING THE STATEMENT OF HEALTH FORM

PLEASE READ CAREFULLY

Thank you for the time that you will take in completing the attached statement of health. **Information obtained through this form and any subsequent information obtained will have no effect on coverage under the group health plan for you or your dependents.** The information obtained will be used to make an appropriate evaluation of the risk characteristics of the group.

Please be sure to provide all requested information for everyone to be covered. The form has two pages and is divided in to 5 sections. They are as follows:

- **General information** about the individuals to be covered
- **Health Questions**
- **Details** for any "yes" answers to the questions (you may attach additional pages if necessary)
- **Declaration** of completeness and accuracy (must be signed by all listed individuals to be covered that are over the age of 18 or older)
- **Authorization to Release Medical Information** (must be completed if you have indicated "yes" to ***any*** of the health questions for ***any*** individual to be covered)
    - Enter the question number (so that we know which diagnosis that the listed provider is treating).
    - Be sure to list the name and date of birth for the individual for which a provider's name is being given.
    - Provide the name and phone number with area code of the provider primarily responsible for treating the condition.
    - Any individual 18 or older for whom a provider has been listed must sign the authorization.

After you have completed the form, review it for completeness, make sure that all necessary signatures are present (**there are 2 signature areas),** seal it in the provided envelope and return it to the person designated by your employer.

Your privacy is important to us and we will do our best to protect the information that you supply and any information obtained from your care providers.

Again, thank you very much for your time.

bardon insurance group, inc. rev 3/05

Statement of Health

Employee Name:		Employer:	

GENERAL INFORMATION - COMPLETE FOR ALL INDIVIDUALS TO BE COVERED

Name	Relation to Employee	DOB	Sex	Height	Weight	Tobacco Use
Employee	Self		□ M □ F			□Yes □No
	Spouse		□ M □ F			□Yes □No
			□ M □ F			□Yes □No
			□ M □ F			□Yes □No
			□ M □ F			□Yes □No
			□ M □ F			□Yes □No

HEALTH QUESTIONS - APPLY TO ALL INDIVIDUALS LISTED ABOVE

Has any enrolling person been diagnosed with, treated for, had any medical advice, or have symptoms that may indicate any of the following:

1. Cancer, leukemia, multiple myeloma or tumor(s)?	□ **Yes**	□ **No**	**14**. Disorder of the kidney, ureters, bladder or urethra?	□ **Yes**	□ **No**
2. Heart attack, high blood pressure, high cholesterol, or other heart / vascular disorder?	□ **Yes**	□ **No**	**15**. GERD (acid reflux), ulcer, or other disorder of the stomach or esophagus?	□ **Yes**	□ **No**
3. Hemophilia or any other blood clotting disorder?	□ **Yes**	□ **No**	**16**. Crohn's disease, diverticulitis, irritable bowel syndrome, or other disorder of the intestines?	□ **Yes**	□ **No**
4. Aplastic anemia, sickle cell anemia, thrombocytopenia, agranulocytosis or other anemia?	□ **Yes**	□ **No**	**17**. Disorder of the bones, joints, spine, muscles, tendons or cartilage?	□ **Yes**	□ **No**
5. Stroke, transient ischemic attach (mini-stroke), or other cerebrovascular disorder ?	□ **Yes**	□ **No**	**18**. Current pregnancy? Due date____/____/____	□ **Yes**	□ **No**
6. Emphysema, COPD, chronic bronchitis, Cystic Fibrosis or other respiratory disorders?	□ **Yes**	□ **No**	**19**. High risk pregnancy, premature delivery, hydatidiform mole, or other pregnancy complication?	□ **Yes**	□ **No**
7. Parkinson's disease, Cerebral Palsy, epilepsy, migranes or other brain disorder?	□ **Yes**	□ **No**	**20**. Disorder of the reproductive organs?	□ **Yes**	□ **No**
8. Multiple Sclerosis, Guillian-Barre, or other nervous system disorder?	□ **Yes**	□ **No**	**21**. Genetic condition, congenital disorder or other birth defect?	□ **Yes**	□ **No**
9. HIV / AIDS or other immune disorder?	□ **Yes**	□ **No**	**22**. Mental / emotional disorder or alcohol / substance abuse?	□ **Yes**	□ **No**
10. Lupus, Scleroderma or other auto-immune disorder?	□ **Yes**	□ **No**	**23**. Major trauma or burn?	□ **Yes**	□ **No**
11. Disorder of the liver, pancreas or gall bladder?	□ **Yes**	□ **No**	**24**. Any other illness, condition or injury not referenced elsewhere on this form for which hospitalization has occurred or other treatment has been recevied in the last 5 years or is anticipated in the next 12 months?	□ **Yes**	□ **No**
12. Diabetes or hypoglycemia (low blood sugar)?	□ **Yes**	□ **No**			
13. Disorder of the thyroid, pituitary, adrenal or other glands?	□ **Yes**	□ **No**			

DETAILS - Complete the following for any "Yes" answers above - Attach additional pages if necessary

Question number	Individual's Name	Diagnosis	Treatment and / or Medications	Date of Onset	Ongoing?
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No
					□ Yes □ No

This form is continued on the next page

Employee Name:		Employer:		Page 2 of 2

DECLARATION

The undersigned does hereby declare that all information given in this form or attached thereto is accurate and complete to the best of their knowledge and belief. In addition, the undersigned understands that failure to provide accurate and complete information may constitute insurance fraud thereby subjecting them to potential prosecution.

X		**X**	
Employee	***Date***	***Spouse***	***Date***
X		**X**	
Other Non-Minor Enrollee (including children 18 or over)	***Date***	***Other Non-Minor Enrollee (including children 18 or over)***	***Date***

Authorization to Release Medical Information - PLEASE READ CAREFULLY

Information to be Released: Any information deemed by Bardon Insurance Group, Inc. to be necessary for making an appropriate underwriting and / or claims adjudication decision. Including but not limited to: medical records, mental health records, substance abuse records, HIV records, results from diagnostic testing and / or telephonic interviews with the provider or the provider's authorized designee.

Purpose of this Authorization: Underwriting, premium rating, and other activities relating to the creation, renewal or replacement of stop loss insurance / excess of loss insurance for an employer sponsored health and welfare benefit plan, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (as defined in C.F.R. Title 45 Subtitle A 164:501).

Parties Authorized to Receive the Information: Bardon Insurance Group (a managing general underwriter for medical stop-loss insurance / excess of loss insurance and life insurance), **Case Management Specialists** (a third party medical consulting / case management firm), and / or any entity that Bardon Insurance Group may reasonably see fit.

Expiration: This authorization will be valid for 12 months from the date that it is signed.

Right to Revoke: You may revoke this authorization at anytime by writing to: Bardon Insurance Group, Director of Underwriting, 8326 E. Hartford Drive, Suite 100, Scottsdale, AZ 85255. The revocation will be effective from the date received by Bardon Insurance Group, Inc.

Special Notice: Signing this release or any information obtained as a result will not affect your coverage under your employer's benefit plan. You do have the right not to sign the release

Parties Authorized to Release the Information:

In regards to any "Yes" answers to the health questions, provide the name and phone number of the treating provider(s) (doctor or otherwise).

Question Number	Individual's Name	Date of Birth	Provider's Name	Provider's Phone Number

By signing below, I acknowledge that I have read and understand this release and authorize the release of my health information as described above. In addition, I understand that a photocopy of this form shall be as valid as the original.

X		**X**	
Employee	***Date***	***Spouse***	***Date***
X		**X**	
Other Non-Minor Enrollee (including children 18 or over)	***Date***	***Other Non-Minor Enrollee (including children 18 or over)***	***Date***

bardon insurance group, inc.

DISCLOSURE STATEMENT

FOR USE ONLY WITH INDIVIDUAL HEALTH STATEMENTS

EMPLOYER NAME:	

In consideration of waiver of the actively at work provision, please list in the provided area any and all participants to who are:

1. covered under COBRA or are eligible for COBRA coverage.
2. not actively at work.
3. dependent children covered under an extension of benefits provision for handicap or disability.
4. dependents known to be disabled or otherwise unable to engage in those activities for which an individual of the same age would ordinarily be expected to do.

Participant's Name	COBRA or COBRA eligible	Disabled	Other (specify)	Diagnosis (if applicable)
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		
	☐	☐		

The undersigned does hereby certify that:

- The above list is the result of a diligent search of all necessary records including but not limited to attendance records, records relating to individuals on leave under the Family and Medical Leave Act, disability records, general employment records, COBRA and COBRA notification records.
- The above list is accurate and complete as of the date signed.
- It is understood that this form will become part of the application for stop loss coverage and as such would ultimately become part of the treaty / policy.
- It is understood that concealment, misrepresentation or omission of any material fact or circumstance may result in rescission of the treaty / policy or reformation of the terms, premium rates and / or aggregate factors under the treaty / policy.

X _____ _____

Authorized Signature of the Employer / Plan Sponsor *Date Signed*

_____

Title