

Application for Stop Loss Coverage

Cigna Health and Life Insurance Company
Mailing Address: Attn: Stop Loss Unit - B2STL
900 Cottage Grove Rd.
Hartford, CT 06152



The Applicant, whose representative has signed below, hereby applies to Cigna Health and Life Insurance Company ("Cigna") for a stop loss insurance policy(ies) providing the insurance coverage as described below in connection with its self-funded health benefit plan.

1. NAME OF APPLICANT: City of North Port

ADDRESS: 4970 City Hall Blvd., North Port, FL 34826

2. AFFILIATED COMPANIES TO BE COVERED: _____

Name

Address (City and State)

_____	_____
_____	_____
_____	_____
_____	_____

Affiliated companies must be part of a common control group as described in Internal Revenue Code §414(c) and the regulations thereunder. Generally, this means that in a parent-subsidiary relationship, the parent must own 80% or more of the subsidiary. In a brother-sister relationship, the same five or fewer people must own at least 80% or more of each company and when considering the smallest percentage interest each person has among the companies, the sum of the smallest interests must exceed 50%. The purpose of this rule is to prevent covering a multiple employer welfare arrangement (MEWA). Any MEWA that wishes to be covered must provide evidence that state law in each jurisdiction in which it has persons to be covered allows the MEWA to operate on a self-insured basis.

3. NUMBER OF EMPLOYEES AT ALL LOCATIONS LISTED ABOVE: 535

INDUSTRY: 9199-Genl Government, NCC

4. NAME OF CLAIM ADMINISTRATOR: Cigna Health and Life Insurance Company

ADDRESS: 900 Cottage Grove Road, Hartford, CT 06152

5. PROPOSED EFFECTIVE DATE: 10/01/2018

6. ☒ INDIVIDUAL STOP LOSS COVERAGE

Benefits covered by Individual Stop Loss Coverage:

☒ Medical ☒ Mental Health/Substance Use Disorders ☒ Pharmacy

☐ Other: _____

PRODUCT FEATURES FOR INDIVIDUAL STOP LOSS COVERAGE:

☐ Tiered Pooling:

High Pooling Point \$ _____

Low Pooling Point \$ _____

Cigna Liability Split _____%

Applies to: ☐ All Claimants

☐ First _____ Claimants

☐ Renewal Planner

☐ Renewal Advantage

☐ Bridge:

☐ ASO to ASO Bridge

☐ ASO to Shared Returns Bridge

☐ Other: _____

INDIVIDUAL STOP LOSS LIMIT: \$ **150,000.00**

High Risk Individuals:

☒ N/A

☐ Yes, individual(s) will be treated as follows:

☐ A separate Individual Stop Loss Limit Applies: \$ _____

☐ Other: _____

MAXIMUM LIFETIME REIMBURSEMENT LIABILITY

FOR INDIVIDUAL STOP LOSS: will be the individual lifetime maximum as set forth in the Benefit Plan less the Individual Stop Loss Limit or will be \$ _____

BENEFIT PERCENTAGE PAYABLE: **100**%

BENEFIT ELIGIBILITY BASIS:

Initial Policy Period: **10/01/2018** to **09/30/2019**

Unless additional options are selected below, claims must be both Incurred and paid during the policy period.

☐ Incurred in _____ months

☐ Paid in 12 months (available only for previously Cigna administered customers)

Run-In Provision: Claims Incurred prior to the policy's Effective Date and paid during the policy period.

☒ N/A ☐ _____ months

☐ Run-In claims are limited to: \$ _____ [per individual]

Run-Out Provision: Claims Incurred during the policy period and paid after termination of the policy.

☒ N/A ☐ _____ months

☐ OTHER REQUESTED PROVISIONS: _____

ESTIMATE MONTHLY INDIVIDUAL PREMIUM RATES*

Product/Benefit Option	PEPM Rate	Product/Benefit Option	PEPM Rate
Multiple Products	\$ 110.73		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$
	\$		\$

* Actual Rates will be contained in the Stop Loss Policy, if and when issued.

COMMENTS

7. ☒ AGGREGATE STOP LOSS COVERAGE

Benefits covered by Aggregate Stop Loss Coverage:

- ☒ Medical ☒ Mental Health/Substance Use Disorders ☒ Fixed Charges
☒ Pharmacy ☐ Dental ☐ Vision
☐ Other: _____

PRODUCT FEATURES FOR AGGREGATE STOP LOSS COVERAGE:

- ☒ Annual Reconciliation
☐ Other: _____

EXPECTED MONTHLY ATTACHMENT FACTOR BY PRODUCT

<i>Product/Benefit Option</i>	<i>Factor</i>	<i>Product/Benefit Option</i>	<i>Factor</i>
HSA Open Access Plus	\$ 802.37		\$
OAP In-Network	\$ 1060.88		\$
Open Access Plus	\$ 1091.46		\$
	\$		\$
	\$		\$
	\$		\$

MINIMUM ATTACHMENT POINT: (Applies to Annual Reconciliation only): \$ **6,557,662.00**

MINIMUM ATTACHMENT PERCENTAGE: **100%**

MAXIMUM REIMBURSEMENT LIABILITY FOR AGGREGATE STOP LOSS: will be \$ **unlimited** for the Policy Year

BENEFIT PERCENTAGE PAYABLE: **100%**

BENEFIT ELIGIBILITY BASIS:

Initial Policy Period: **10/01/2018** to **09/30/2019**

Unless additional options are selected below, claims must be both Incurred and paid during the policy period.

- ☐ Paid in 12 months (available only for previously Cigna administered customers)

Run-In Provision: Claims Incurred prior to the policy's Effective Date and paid during the policy period.

- ☒ N/A ☐ _____ months

- ☐ Run-In claims are limited to: \$ _____

Run-Out Provision: Claims Incurred during the policy period and paid after termination of the policy.

- ☒ N/A ☐ _____ months

- ☐ OTHER REQUESTED PROVISIONS: _____

ESTIMATED MONTHLY AGGREGATE PREMIUM RATES: \$ **3.77** *

* Actual Rates will be contained in the Stop Loss Policy, if and when issued.

COMMENTS

8. The Applicant agrees that:

- a. The Applicant has read the entire Application and certifies that the underwriting information presented to Cigna, whether provided by the Applicant or any person acting on behalf of or at the direction of the Applicant, voluntarily or in response to Cigna's request, is complete and accurate. Such underwriting information, if any, is considered to be part of this Application.
- b. Any policy issued based on this Application, together with any of its Schedule of Insurance, amendments or riders, shall control the stop loss insurance coverage and terms and conditions of such insurance. In the event of a conflict between the Application and terms of the Policy, the Policy shall prevail.
- c. No person, other than a duly authorized officer of Cigna or its delegate has authority to accept and approve this Application, or otherwise alter any policy provisions or waive any of Cigna's rights or requirements.

FRAUD WARNING: 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.

All application statements, in the absence of fraud, made by the Applicant shall be deemed to be representations, not warranties.

DATED AT _____ THIS _____ DAY OF _____ 20____

APPLICANT **City of North Port** _____

BY _____ TITLE _____
(Applicant's designated individual's signature)

LICENSED AGENT NAME: _____

AGENT SIGNATURE: _____ FLORIDA LICENSE NUMBER: _____

ONCE COMPLETED AND SIGNED, MAIL TO THE STOP LOSS CONTRACTING UNIT.

Mailing Address: Cigna Health and Life Insurance Company
Attn: Stop Loss Unit - B2STL
900 Cottage Grove Rd.
Hartford, CT 06152