

The Employers' Fire Insurance Company • OneBeacon America Insurance Company •
One Beacon Insurance Company • OneBeacon Lloyd's of Texas • OneBeacon
Midwest Insurance Company • Pennsylvania General Insurance Company
(Stock companies owned by the **OneBeacon Insurance Group**)

Application for Group Stop Loss Insurance

The undersigned Applicant requests the Group Stop Loss Insurance benefits shown herein and provided by the applicable company listed above (the "Company"), and agrees to be bound by the terms and provisions of the Group Stop Loss Policy.

Full Legal Name of Applicant: _____

Address (Street, City, State and ZIP Code): _____

Key Contact: _____ **Telephone:** _____ **Tax ID:** _____

Applicant is a: Corporation Labor Union Partnership Association Proprietorship
 Other

Nature of the Business of the Group to be Insured: _____ **Standard**

Industry Code: _____ **Requested Effective Date:** _____

Total Number of Eligible Persons: **Employees:** _____ **Retirees:** _____

Are retirees covered? Yes No

Covered Affiliates or Subsidiaries: _____ **Addresses of Covered Affiliates or Subsidiaries:**

Full Legal Name of Administrator: _____

Address (Street, City, State and ZIP Code): _____

Key Contact: _____ **Telephone:** _____

Agent or Broker: _____

Social Security Number or Tax ID: _____

Address (Street, City, State and ZIP Code): _____

Specific Excess Loss Insurance: Yes No

Benefit Period: _____

Example: Eligible Expenses incurred from 10/1/07 through 12/31/08 and paid from 1/1/08 to 12/31/08

Specific Deductible per Covered Person: _____

Specific Percentage Reimbursable: _____

Minimum Specific Benefit per Covered Person: \$1,000,000 \$2,000,000

Covered Expenses under Specific Excess Loss: Medical Prescription Drug

Specific Premium per Covered Employee per Month:

Contract Type	Premium Rates	Number of Employees
Individual		
Dual		
Employee and Child		
Family		
Composite		

1. **Specific Terminal Liability Endorsement** Yes No

2. **Aggregating Specific Deductible Endorsement** ___ Yes \$ _____ ___ No

Aggregate Excess Loss Insurance: ___ Yes ___ 125% ___ No **Other** _____

Benefit Period: _____
Example: Eligible Expenses incurred from 10/1/07 through 12/31/08 and paid from 1/1/08 to 12/31/08

Covered Expenses under Aggregate Excess Loss Coverage Medical Prescription Drug

Aggregate Percentage Reimbursable: _____

Maximum Aggregate Benefit ___ \$1,000,000 ___ \$2,000,000

Minimum Annual Aggregate Deductible _____

Aggregate Excess Loss Premium per Covered Individual per month: _____

Monthly Aggregate Factors (includes 25% corridor unless otherwise stated.)

Contract Type	Monthly Attachment Factor	Number of Employees
Individual		
Dual		
Employee and Child		
Family		
Composite		

It is understood and agreed by the undersigned that:

- a. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigns representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Group Stop Loss Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending or while the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
- b. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the applicable Plan Document along with this Application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company, If the Company does not receive the Plan Document, the Company may refund all premium and the Application shall have been null and void when signed. No Group Stop Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.

- c. The Company will evaluate the undersigned's risk, as requested by this Application; the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
- d. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and required premiums paid.
- e. The receipt by the company of the First month's premium and deposit of any check drawn in connection with the Application shall not constitute an acceptance of liability. In the event the Company does not approve this Application its sole obligations shall be to refund such sum to the undersigned.
- f. The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administration are binding on the undersigned.

The undersigned has read the entire Application for Group Excess Loss Insurance, and completed the Disclosure form and understand that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: _____

Signature of Authorized Person: _____

Print Name: _____ **Title:** _____

Date: _____

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____