BCS Insurance Company
2 Mid America Plaza, Suite 200
Oakbrook Terrace, Illinois 60181
800.621.9215
bcsins.com

APPLICATION FOR STOP LOSS INSURANCE

Applicant Information - Please complete in full			
Full Legal Name of Group (*to appear on Policy*) **City of Ann Arbor**			Effective Date **January 01, 2021**
Tax ID Number (*attach W-9*)	Telephone Number		
Corporate Address **301 E. Huron Street**	City **Ann Arbor**	State **MI**	Zip Code **48107**
Mailing Address (*if different than above*)	City	State	Zip Code

Enrollment

Network(s) Utilized	
Medical: **BC and/or BS Network**	Rx: **Keenan/ESI**
Utilization or Case Manager, if any:	

Business Affiliates (Attach additional sheet if necessary) ☐ **Not Applicable, no other Business Affiliates**			
#1 Full Legal Name			
Address	City	State	Zip Code
#2 Full Legal Name			
Address	City	State	Zip Code

Producer (*Agent/Broker*) ☐ **Not Applicable**			
Name **Marsh & McLennan Agency LLC**		State License Number for Applicant's Situs State*	
Tax ID Number (attach W-9)*	Telephone Number	Email	
Mailing Address **3331 W. Big Beaver Rd., Suite 200**	City **Troy**	State **MI**	Zip Code **48084**

Secondary Producer (*Agent/Broker*) ☐ **Not Applicable**			
Name		State License Number for Applicant's Situs State*	
Tax ID Number (attach W-9)*	Telephone Number	Email	
Mailing Address	City	State	Zip Code

Administrator (*TPA*)			
Full Legal Name **Blue Cross Blue Shield of Michigan**			Tax ID Number (*attach W-9*)
Address **600 E. Lafayette Blvd.**	City **Detroit**	State **MI**	Zip Code **48226-2998**
Mailing Address (*if different than above*)	City	State	Zip Code
Key Contact Person	Email	Telephone Number	

Secondary Administrator (*TPA*) ☐ **Not Applicable**			
Full Legal Name		Tax ID Number (*attach W-9*)*	
Address	City	State	Zip Code

*If available at time of application and if applicable.

Mailing Address (*if different than above*)	City	State	Zip Code
Key Contact Person	Email	Telephone Number	

The Undersigned Applicant Hereby Agrees That:

It is understood and agreed that by signing this Application, the applicant employer (the "Applicant") agrees as follows:

1. The Applicant hereby applies to BCS Insurance Company ("Company") for Stop Loss Insurance in connection with self-funded coverage as outlined in the signed Firm Stop Loss Proposal that accompanies this Application (the "Proposal").
2. The Applicant shall furnish to the Company upon request a copy of the Plan Document that describes the benefits that are covered. In the event of a material variance between the Plan Document received and the benefit provisions upon which the terms and rates were provided for stop loss insurance coverage, the Company at its option, may rerate and/or withdraw coverage.
3. The Policy shall become effective on the first day of the Policy Period specified in the Proposal, unless otherwise agreed to by the Company in writing. The receipt of premium by the Company or its affiliates in connection with the Policy shall not constitute an acceptance of liability. In the event that the Company does not accept the request for stop loss insurance submitted by the Applicant, the Company's sole obligation will be to return any received premium. The Company also has the right to withdraw or cancel any offer of coverage if a signed Application and Schedule are not received within 30 days after issuance by the Company. Once any offer of stop loss coverage is withdrawn or canceled, the Company's sole obligation is to return any received premium.
4. If an Administrator is used by the Applicant to remit premiums or administer claims, both premium remittance and claims administration must adhere to the guidelines as set forth by the Company. The Applicant acknowledges that the Administrator is the Applicant's agent and not the agent of the Company.
5. The Applicant's Complete Claims History (as defined on Page 3 of this Application) and any other information furnished during the stop loss proposal process by or on behalf of the Applicant are the primary data elements on which the Company's Proposal is based. If the Applicant fails to disclose all information that is, or through a diligent review, could have been included in the Complete Claims History, the Company will have the right to revise the premium rates, deductibles, factors and terms and conditions of the Policy in accordance with the Company's underwriting practices in effect at the time the Policy was underwritten, retroactive to the Effective Date.
6. Any coverage resulting from this Application shall be subject to the terms, conditions and provisions of the Policy herein applied for.

By signing below, the Applicant agrees that the coverage requested herein is not in effect until (1) this signed and completed Application and Disclosure Statement are approved by the Company, and (2) the Schedule for Stop Loss Insurance has been issued by the Company and formally accepted by Applicant.

Please see attached page.

Printed Name of Applicant's Authorized Representative

Signature of Applicant's Authorized Representative | Date | Title

Print Name of Producer | Print Name of Sub-Producer

Signature of Producer | Signature of Sub-Producer

COMPLETE CLAIMS HISTORY means all of the following:

1) A census of all Covered Persons which, at minimum, includes Persons legally employed by the Applicant or an Affiliate, dates of birth, gender, zip code of residence, type of coverage, and summary information about dependents, participating COBRA beneficiaries and retirees; and

2) A member-level specific stop loss summary which includes, at minimum, member name, amount paid and diagnosis for a minimum of thirty-six (36) consecutive months immediately preceding the Application Date; and

3) Any injury, illness or disease that resulted in Eligible Expenses Paid or Incurred on behalf of any Covered Person in an amount in excess of 50% of the Specific Deductible or has the potential to exceed 50% of the Specific Deductible, including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, and case management reports for a minimum of twelve (12) consecutive months immediately preceding the Application Date; and

4) Any injury, illness or disease that relates to a classification of disease that the Company has designated as a potential Large Claim by virtue of its International Classification of Disease ("ICD") Code; including, at minimum, amount paid, diagnosis, prognosis, dates of service, claimant status, and case management reports for a minimum of twelve (12) consecutive months immediately preceding the Application Date; and

5) Monthly paid claims and enrollment for a minimum of thirty-six (36) consecutive months immediately preceding the Application Date (If Aggregate Stop Loss insurance is being applied for); and

6) Pre-certifications, utilization reviews, pending and denied claim reports, and claims in audit for a minimum of twelve (12) consecutive months immediately preceding the Application Date.

FOR THE CITY OF ANN ARBOR

By _____
Christopher Taylor, Mayor

By _____
Jacqueline Beaudry, City Clerk

Approved as to substance:

By _____
Tom Crawford, City Administrator

Approved as to form and content

By _____
Stephen K. Postema, City Attorney