Employer Disclosure Form

HIPAA Privacy permits the release of Protected Health Information (PHI) for the purpose of evaluating and accepting risk associated with the Plan Sponsor as part of "health care operations". Medova Healthcare and the Reinsurance Carrier(s) utilized by Medova Healthcare, shall use the information provided solely for the purpose of evaluating the acceptability of this risk and shall not disclose any PHI collected except in performing this risk evaluation.

Medova Healthcare will rely upon the information provided in this Disclosure Form, which will become part of the application for stop loss coverage to the Reinsurance Carrier(s) selected. The purpose of this Form is to allow Medova on behalf of our affiliated Reinsurance Carriers, to take underwriting action on all known individuals in the categories listed below. It is the Plan Sponsor's responsibility, either directly or through their designated representative, to accurately report all claims known as of the date of this Disclosure by making a thorough review of all applicable records. Such record shall include historical claim reports, disability records, payroll records, current information from administrators, insurers, utilization management companies, managed care companies and any Agent/Broker of the Plan Sponsor. In exchange, the Reinsurance Carrier will accept the liability for any truly unknown claimants. This Disclosure Form must be completed and signed by the appropriate parties no earlier than thirty (30) days prior for new business (or earlier than thirty (30) days if prior approval is authorized by the underwriter) and no later than ten (10) days after, the proposed Effective Date of stop loss coverage and received by Medova Healthcare within five (5) days (non-business) of completion.

Please note, when completed, this form should include and disclose all known health conditions or known health claims on Plan Participants that may be on a leave of absence, short or long term disability, FMLA, COBRA, other Paid time off, or retirees covered under the plan and for whom coverage is requested in the quote.

Disclosures

Please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents, including all proprietors, partners, corporate officers, employees, spouses, and dependent children to the extent permitted by applicable law.

When completing this Form, remember that Plan Participants may include those on short or long-term disability, COBRA, FMLA, leave of absence, extension of benefits, sick time, vacation time or retirees covered under the plan and for whom coverage is requested in the quote. All of the Plan Participants for which the above situations apply, should be identified accordingly, e.g., John Smith, COBRA, effective xx/xx/xx. List on page 3 of this Disclosure Form all Plan Participants whom there is a "yes" response to on any of the following questions:

1. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn? □ Yes □ No

2. Has your most recent medical plan renewal exceeded a 20% premium rate increase? □ Yes □ No
   Date of most recent medical plan renewal: _____

3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent? □ Yes □ No

4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness? □ Yes □ No

5. During the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days? □ Yes □ No

6. Has any employee or dependent had any medical conditions in the past 24 months requiring medical care, prescription management, or hospitalization in the amount of $5,000 or more? □ Yes □ No

7. Is any employee or dependent currently hospitalized or has been in the last 6 months? □ Yes □ No

8. Has any employee or dependent been diagnosed within the past 12 months with a condition represented by any of the ICD-9 / ICD-10 codes listed on page 4 of this Form? □ Yes □ No

9. Within the past 3 years has any employee or dependent been diagnosed, treated for, or received prescription medication by a licensed medical provider for one of the following diseases or disorders? □ Yes □ No

   If yes, check all that apply:
   - □ Cancer (any type)
   - □ Hepatitis
   - □ Lung disease or respiratory problem (any type)
   - □ Morbid Obesity
   - □ Heart disease or disorder (any type)
   - □ Congenital abnormality
   - □ Organ, tissue or cell transplant
   - □ Vascular disease (any type)
   - □ Liver disease (any type)
   - □ Neurological disorder (any type)
   - □ Kidney disease (any type)
   - □ Immunological disorder (reportable types)
   - □ Pancreatic disorder (any type)
   - □ Alcohol or drug addiction or abuse

If you have answered "Yes" to any of the questions on page 2 of this Form, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Question Number	Check (X) if Employee	Check (X) if Dependent	Age	Date of Treatment / Disease / Disorder	Name of Disease / Disorder	Nature of Medication	Date of Recovery	$ Amount of Claims	Current Treatment

In addition to any information provided above, please note if you are providing: □ **Employee Health Applications** □ **Claims Information**

If the Plan Sponsor fails to disclose any Plan Participant known to fall into one of the above eight categories, either intentionally or because a thorough review of all records was not conducted, the Reinsurance Carrier will have no liability for claims on the Plan Participant who was not disclosed.

Plan Sponsor: _____ Claims Administrator: Medova Healthcare Financial Group Agent / Broker: Medova Healthcare Financial Group

Signature: _____ Signature: _____ Signature: _____

Name: _____ Name: Daniel Whitney Name: Daniel Whitney

Title: _____ Title: CEO / President Title: CEO / President

Date: _____ Date: _____ Date: _____

mm/dd/yyyy mm/dd/yyyy mm/dd/yyyy

ICD-9 / ICD-10 Codes for Disclosure Notification

Please list all Plan Participants who have been diagnosed with, or treated for, any of the codes listed under the following categories during the current Benefit Period:

ICD-9 Codes	ICD-10 Codes	Diagnosis	ICD-9 Codes	ICD-10 Codes	Diagnosis
038-080	A40-A49.9; A70-A75; A80-B34	Infectious Diseases	628-628.9	N97	Infertility
140-239.9	C00-D48	Malignancies, Neoplasms, Leukemia, Lymphoma	710-710.9	M33-M35	Autoimmune Disorders
250-250.9	E10-E14	Diabetes	715-739	M15-M25; M35.7; M40-M54; M60-M63; M65-M68; M70-M72; M75-M76; M79-M99	Diseases of Musculoskeletal System & Connective Tissue
270-279.9	D84; D89; E65-E68; E70-E89	Other Metabolic & Immunity Disorders	740-779.9	Q00-Q99; P00-P96	Prematurity & Congenital Disorders
280-288.9	D50-D89	Diseases of Blood & Blood Forming Organs	800-806.9/851-854.1	S02; S06; S12-S14; S22; S24; S32; S34;	Intracranial & Spinal Cord Injuries
330-337.9	E75; G11-G12; G20-G32; G90-G91; G95	Hereditary & Degenerative Disease of Central Nervous System	860-869.1	S20-S39	Other Traumatic & Internal Injuries
340-349.9	G35-G43; G47.4; G60; G80-G99	Other Disorders of Central Nervous System	885-887.7/895-897.7	S08; S48; S58; S68; S78; S88; S98; T05; T09.6	Traumatic Amputations
402-438.9	I10-I69	Heart and Vascular Diseases	941-949.5	T20-T32	Burns
440-442.9/444-444.9	I70-I72; I74	Atherosclerosis, Aortic & Other Aneurysms	952-957.9	S14; S24; S34; S44; S54; S64; S74; S84; S94	Spinal Cord & Nerve Injuries
501-516.9	J61-70; J85-89	Pulmonary Disease	996-997.9	I97; N99; T81-T87	Complications of Procedures
555-579.9	K50-K93	Liver & Intestinal Disorders	V23-V23.9	O09	Supervision of High Risk Pregnancies
584-588.9	N17-N19; N25-N27	Renal Disorders	V42-V59.9	R68; Z41-Z44; Z46; Z48; Z49; Z51-Z52; Z87; Z93-Z99	Transplant Status & Other Conditions Influencing Health Status