A DIVISION OF COMPANION LIFE INSURANCE COMPANY

Plan Participant Disclosure Statement
Producer Instructions

Thank you for your interest in iiSi and for your effort in gathering Plan Participant Disclosure Statements. This additional disclosure information is required *only* when individual participant claims experience is unavailable (e.g., small fully-insured employers) and is intended to supplement the Plan Sponsor Disclosure Statement that is also required on all newly-sold cases. Information obtained from these statements is vital to the final sold-case underwriting process on groups without individual participant claims experience, and can also be a valuable tool to the employer when evaluating self-funding as a benefit financing option.

Please provide to all employees the Plan Participant Disclosure Statement and the accompanying instruction sheet. Also, please designate the individual to whom the completed forms should be returned.

Requirement Parameters

- Plan Participant Disclosure Statements are required on all new-business sold cases where individual participant claims experience is unavailable.
- Plan Participant Disclosure Statements must be completed, signed, and dated by all employees no sooner than three months prior to the proposed effective date of the stop loss coverage.
- If other, similar forms (i.e., from another carrier) have already been completed by all employees, iiSi will accept those forms provided they are current to within three months of the proposed effective date of the stop loss coverage.
- Plan Participant Disclosure Statements may be submitted at any time during the underwriting process, but are not required until the final sold-case underwriting process as a supplement to the Plan Sponsor Standard Stop Loss Disclosure Form. From a timing standpoint, iiSi strongly recommends that these participant forms be submitted in conjunction with the Standard Stop Loss Disclosure Form.
- If submitted at any time after the initial proposal is released, stop loss terms may be revised.

Please contact your iiSi Regional Marketing Director or Underwriter for additional information.

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Plan Participant Disclosure Statement

Plan Participant Instructions

Thank you for your time and effort in thoroughly and accurately completing this Plan Participant Disclosure Statement. Information obtained from this form and any subsequent information that may be obtained will have no effect on plan coverage for you or your dependents. The information will be used only to accurately assess the risk characteristics of your employer group.

Please provide all requested information for you and any dependents to be covered. The form is one page and is divided into the three following sections:

1. General Employee Information
2. Covered Dependent Information
3. Medical Information (for you and your dependents)

   For any "Yes" answers, please provide complete details (attached additional sheets if needed), which include:

   - Name of person referenced
   - Medical condition
   - Current and past treatment including medications and/or prescriptions
   - Date range to include date of diagnosis and date of last treatment and/or medication/ prescription
   - Prognosis and status of the condition, and if the condition is ongoing

After you have completed the form, please review it for accuracy and completeness and sign and date where indicated. Please seal your form in an envelope and return it to the individual designated by your employer.

Your privacy is important and will be protected.

Again, thank you for your time and effort.

Plan Participant Disclosure Statement

TO BE COMPLETED BY THE EMPLOYEE

iiSi A DIVISION OF COMPANION LIFE INSURANCE COMPANY

Reset Form

Employee Information

Employer			Date of Hire	
Employee Last Name	First Name / M.I.	Date of Birth		Home Phone
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender ☐ Male ☐ Female	Height	Weight	Tobacco User ☐ Yes ☐ No

Covered Dependents Information

Person	Last Name	First Name	Gender	D.O.B.	Height	Weight	Tobacco User
Spouse							☐ Yes ☐ No
Child 1							☐ Yes ☐ No
Child 2							☐ Yes ☐ No
Child 3							☐ Yes ☐ No
Child 4							☐ Yes ☐ No
Child 5							☐ Yes ☐ No

Medical Information (for you and all dependents to be covered)

1. At any time in the past five (5) years, have you or any dependent consulted a health care provider, received treatment (including prescription medications), or been hospitalized for any of the following conditions, disorders, or diseases?

	Yes	No		Yes	No
• Cancer, Leukemia, Multiple Myeloma or Tumor(s)	☐	☐	• HIV/AIDS or other Immune System Disorder	☐	☐
• Heart Attack or other Heart/Vascular Disorder	☐	☐	• Lupus, Scleroderma or other Auto Immune Disorder	☐	☐
• Hemophilia or other Blood Clotting Disorder	☐	☐	• Pancreas or Kidney Disorder	☐	☐
• Aplastic Anemia or Sickle Cell Anemia	☐	☐	• Cirrhosis, Hepatitis or other Liver Disorder	☐	☐
• Thrombocytopenia, Agranulocytosis or other Anemia	☐	☐	• Diabetes	☐	☐
• Stroke or other Cerebrovascular Disorder	☐	☐	• Pituitary, Adrenal, or other Gland Disorder	☐	☐
• Cystic Fibrosis or other Respiratory Disorder	☐	☐	• Crohn's, Diverticulitis, or other Intestinal Disorder	☐	☐
• Emphysema, COPD, or Chronic Bronchitis	☐	☐	• Arthritis, Rheumatism, or other Bone/Joint Disorder	☐	☐
• Parkinson's Disease, Cerebral Palsy, or Epilepsy	☐	☐	• Back or Spine Disorder	☐	☐
• Other Brain Disorder	☐	☐	• Genetic or Congenital Disorder or other Birth Defect	☐	☐
• Multiple Sclerosis or Guillain-Barre' Syndrome	☐	☐	• Mental/Nervous Disorder or Alcohol/Substance Abuse	☐	☐
• Other Nervous System Disorder	☐	☐	• Major Trauma or Burn	☐	☐

2. Are you or any dependent currently pregnant or undergoing fertility treatment? ☐ Yes ☐ No

3. Are you or any dependent anticipating surgery? ☐ Yes ☐ No

4. Are you or any dependent an organ or tissue transplant donor, recipient, or candidate? ☐ Yes ☐ No

5. Are you or any dependent disabled or unable to perform the normal activities of daily living or self care? ☐ Yes ☐ No

6. Are you or any dependent currently taking prescription medication? (Confirm name, dosage, and frequency.) ☐ Yes ☐ No

7. Provide complete details in the section below for all "Yes" answers. Please use additional paper if necessary.

#	Person	Medical Condition / Diagnosis	Treatment / Prescription Medication Details	Date Range	Prognosis / Status
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:
				From: To:	Ongoing? ☐ Yes ☐ No Date of Last Doctor Visit:

I hereby certify that, to the best of my knowledge and belief, the information provided in this is disclosure is complete and accurate.

Employee Signature: _____ Date: _____