Allegiance Life & Health Ins. Co., Inc. (AL&H)
Large Group Disclosure Statement
Confidential

Employer: Proposed Effective Date: / /

The terms of coverage are not finalized until AL&H receives, reviews, verifies the accuracy of, and approves the following information:

1. Please list participants on **Appendix A** if yes is checked on all of the following that apply:

A. Any plan participant with claims that have been paid, pended or denied in the past 12 months, which exceed $25,000. If name of participant is not known, please list diagnosis according to your large claim report. ☐ Yes ☐ No If yes, please fill in participant's information on Appendix A.
B. Any plan participant that is disabled? ☐ Yes ☐ No If yes, please fill in participant's information on Appendix A.
C. Any plan participant that is currently in the hospital or an institution? ☐ Yes ☐ No If yes, please fill in participant's information on Appendix A.
D. Any plan participant that is currently, or is scheduled to be, absent from work due to Family Medical Leave, or Leave of Absence. Is the absence due to a health condition? ☐ Yes ☐ No If yes, please fill in participant's information on Appendix A.
E. Participants with a history, or a current diagnosis, of any chronic medical conditions, serious disease or disorder including but not limited to diabetes, cancer, heart disease, kidney problems, AIDS or AIDS Related Complex, HIV Positive, (ARC), leukemia, high risk pregnancy, severe cardiovascular disease, any severe disorder of a major organ system, severe burns or trauma, any form of paralysis, premature infancy, and/or has a major surgical operation anticipated or planned, or is a potential organ transplant candidate? ☐ Yes ☐ No If yes, please fill in participant's information on Appendix A.

"Plan Participant" means a covered employee, covered dependent, participating COBRA beneficiary, any person eligible for COBRA, anyone born within 30 days of the Proposed Effective Date, covered retiree, or any other person that may be covered under the Employer's benefit plan.

- The Employer, and the Broker acting as an agent of the Employer, hereby both individually certify and represent that the information and documentation submitted are complete and accurate and that nothing has been omitted.
- The Employer, and the Broker acting as an agent of the Employer, both individually understand and agree that if any individual is not appropriately disclosed to and approved by AL&H, the proposed terms of coverage may be changed.
- The Employer, and the Broker acting as the agent of the Employer, both individually further acknowledge and agree that if any inaccurate or incomplete information has been provided, the proposal for coverage may be withdrawn or coverage may be terminated retroactive to the Effective Date.

Broker:	**Employer:**
Authorized Representative:	**Authorized Representative:**
Date: / /	**Date: / /**

- This form must be signed and completed by the Broker and the Prospective Policyholder before a firm quote can be issued.
- After the form is completed and signed it must be sent to Allegiance Life & Health Insurance Company, Inc., within 24 hours after execution.

Appendix A (Confidential)

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
On FMLA or Leave of Absence? ☐ Yes ☐ No	Expected Return To Work Date: / /	Benefits Paid & Pended Last 12 months:	

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
On FMLA or Leave of Absence? ☐ Yes ☐ No	Expected Return To Work Date: / /	Benefits Paid & Pended Last 12 months:	

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
Expected Return To Work Date: / /	Benefits Paid & Pended	Last 12 months:	

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
On FMLA or Leave of Absence? ☐ Yes ☐ No	Expected Return To Work Date: / /	Benefits Paid & Pended Last 12 months:	

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
On FMLA or Leave of Absence? ☐ Yes ☐ No	Expected Return To Work Date: / /	Benefits Paid & Pended Last 12 months:	

Name:	☐Employee ☐Dependent	Date of Birth: / /	☐Male ☐Female
Date Disabled: / /	Diagnosis or Nature of Disability:		
Currently Hospital or Institution Confined ☐ Yes ☐ No Name of Institution:			
On FMLA or Leave of Absence? ☐ Yes ☐ No	Expected Return To Work Date: / /	Benefits Paid & Pended Last 12 months:	