



# MARKEL INSURANCE COMPANY

## GROUP STOP LOSS APPLICATION

1. Policyholder Name \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Telephone Number (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_\_
2. Names and addresses of all subsidiaries or affiliated companies whose employees will be covered.  
 \_\_\_\_\_  
 \_\_\_\_\_
3. Number of employees at all locations listed above:  
 Single: \_\_\_\_\_  
 Composite: \_\_\_\_\_  
 Family: \_\_\_\_\_  
 COBRA Continuees: \_\_\_\_\_  
 Retirees: \_\_\_\_\_
4. Name of Plan Administrator: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 (City) (State) (Zip)
5. Effective date: 12:01 am on \_\_\_\_\_
6. Benefits provided: Medical and Prescription Drugs
7. Optional benefits provided by rider:  
 Dental     Weekly Income     Vision     Other \_\_\_\_\_

### AGGREGATE EXCESS LOSS INSURANCE

*This section must be completed.*

8. Benefits Included: Medical and Prescription Drugs
9. Optional benefits provided by rider
 

<u>BENEFIT</u>	<u>YES</u>	<u>NO</u>
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Weekly Income	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>
10. Maximum aggregate benefit: \_\_\_\_\_
11. Benefit percentage payable: \_\_\_\_\_

12. Policy basis/Benefit period (check one):

- Covered expenses incurred during the policy year and paid during the policy year.
- Covered expenses paid during the policy year.
- Covered expenses incurred within \_\_\_\_\_ month(s) prior to coverage effective date and paid during the policy year.
- Covered expenses incurred during the policy year and paid within \_\_\_\_\_ month(s) after the policy year.

*The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or subsequent coverage.*

13. Annual aggregate premium: \_\_\_\_\_

14. Monthly aggregate premium per employee: \_\_\_\_\_

15. Aggregate monthly factors

Single: \$ \_\_\_\_\_

Family: \$ \_\_\_\_\_

Composite: \$ \_\_\_\_\_

16. Covered units/Enrollees

Single: \_\_\_\_\_

Family: \_\_\_\_\_

Composite: \_\_\_\_\_

17. Initial Attachment Point: \_\_\_\_\_

18. Minimum Attachment Point: \_\_\_\_\_

**SPECIFIC EXCESS LOSS INSURANCE:** YES  NO

*Complete this section ONLY if Specific Excess Loss Insurance is selected as an option.*

19. Deductible per covered person: \_\_\_\_\_

20. Maximum specific benefit minus the deductible: \_\_\_\_\_

21. Benefit percentage payable: \_\_\_\_\_

22. Expense eligibility claim basis (check one):

- Covered expenses incurred during the policy year and paid during the policy year.
- Covered expenses paid during the policy year.
- Covered expenses incurred within \_\_\_\_\_ month(s) prior to coverage effective date and paid during the policy year.
- Covered expenses incurred during the policy year and paid within \_\_\_\_\_ month(s) after the policy year.

*The applicant agrees and acknowledges that, depending upon the coverage selected and the terms of any expiring coverage or coverage the applicant may elect in the future, the applicant may experience losses that are not covered under the policy, when issued, or under any such prior or*

*subsequent coverage.*

23. Specific premium rates:

Single: \$ \_\_\_\_\_

Family: \$ \_\_\_\_\_

Composite: \$ \_\_\_\_\_

20. A deposit of \$\_\_\_\_\_ is enclosed to apply to the first payment under the policy, if issued, subject to the requirements below. If the application is not accepted, the deposit will be returned.

It is understood and agreed that:

1. Any Excess Loss Insurance resulting from this application shall be as described in and shall be subject to the terms and provisions of the policy, when issued. Such policy shall become effective on the date specified in this application; provided that, including, without limitation:
  - a. a true and correct Disclosure Statement has been received;
  - b. the underwriting requirements have been satisfied;
  - c. the required premiums have been paid;
  - d. a copy of the executed Plan is received and acceptable to the Company pursuant to paragraph b below; and
  - e. the policy has been issued.
2. Within 90 days from the date of this application, the applicant shall furnish to Markel insurance Company, for approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the approved third party administrator or the Company. No Policy will be released nor claim reimbursed until a Plan is received and accepted by the Company. If we do not receive a copy of the Plan within 90 days of the date of this application, all premium will be refunded and coverage will be null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provisions upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the applicant of such variances and decline to release the policy until an amended Plan is received and accepted. In the event an amended Plan is not received and accepted by the Company within 30 days of such notice, all premium will be refunded and coverage will be null and void retroactive to the proposed effective date.
3. The applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.
4. Receipt by the Company of the initial premium and the deposit of any check drawn in connection with this application shall not constitute an acceptance of liability. In the event that the Company does not approve this application, its sole obligation shall be to refund the deposit premium to the applicant.
5. The applicant represents that the statements and declarations made in this application, the Disclosure Statement, and in the Plan referred to in this application are true and complete and that the policy will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this application and the Plan shall form a part of the policy, and the policy shall embody all agreements existing between the applicant or its authorized agent and the Company relating to the excess loss insurance for which application is being made.

*NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.*

The applicant represents that it, directly or through its authorized agent, has read this application in its entirety and has been given the opportunity to ask any questions it may have. The applicant further understands that the insurance requested does not start unless this application is approved and accepted by the Company.

Dated \_\_\_\_\_

Signature of Employer \_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Dated \_\_\_\_\_

Signature of Producer \_\_\_\_\_

Name \_\_\_\_\_

Producer's Address \_\_\_\_\_

**MARKEL INSURANCE COMPANY**

4600 Cox Road

Glen Allen, VA 23060