UNIMERICA INSURANCE COMPANY

A Stock Company
Administrative Offices: 1 Optum Circle, MN101, Eden Prairie, MN 55344
Phone: 1-800-454-0233

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by Unimerica Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: Effingham County Board of Commissioners
Address: 804 S. Laurel St., Springfield, GA 31329
Key Contact: _____ **Telephone:** (912) 754-2123 **Tax ID:** 58-6000821

Applicant is a: ☐ **Corporation** ☐ **Labor Union** ☐ **Partnership** ☐ **Association** ☐ **Proprietorship** ☐ **Other:** _____
Nature of Business of the Group to be Insured: _____ **Requested Effective Date:** January 1, 2025

Total number of eligible persons: Employees: _____ **Retirees: n/a**
Are retirees covered: ☐ **Yes** ☒ **No.**

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

_____ _____

Full Name of Administrator: Meritain Health, Inc. **Pharmacy Benefit Manager:** CVS Caremark
Address: P.O. Box 853921 , Richardson, TX 75085-3921
Key Contact: _____ **Telephone:** _____
Agent or Broker: _____
Tax ID: _____
Address: _____

SPECIFIC EXCESS LOSS INSURANCE ☒ Yes ☐ No

Benefit Period: Covered Expenses Incurred from January 1, 2024 through December 31, 2025 and Paid from January 1, 2025 through December 31, 2025.

Specific Deductible: per Covered Person: $125,000

Specific Percentage Reimbursable: 100%

Maximum Specific Benefit per Covered Person: ☒ Unlimited ☐ Other

Covered Expenses under Specific Excess Loss: ☒ Medical ☒ Stand Alone Prescription Drug Program

Common Accident Provision: ☒ Yes ☐ No

Description:	Specific Premium Rates per month
Employee	$ 138.03
Employee + Spouse	$ 311.87
Employee + Child(ren)	$ 243.88
Employee + Family	$ 433.08

Specific Accommodation Reimbursement Endorsement	☒ Yes	☐ No
Specific Step-Down Deductible Endorsement	☐ Yes	☒ No
Specific Terminal Liability Endorsement	☐ Yes	☒ No
Aggregating Specific Deductible Endorsement	☐ Yes	☒ No
Independent Review Organization Extended Liability Endorsement	☒ Yes	☐ No

AGGREGATE EXCESS LOSS INSURANCE: ☒ **YES** ☐ **NO**

Benefit Period: Covered Expenses Incurred from January 1, 2025 through December 31, 2025, and Paid from January 1, 2025 through December 31, 2025.

Covered Expenses under Aggregate Excess Loss Coverage: ☒ Medical ☐ Dental ☐ Vision
☒ Stand Alone Prescription Drug Program
☐ Other (Please Specify)

Aggregate Percentage Reimbursable: 100%
Maximum Aggregate Benefit: ☐ $500,000 ☒ $1,000,000 ☐ Other

Minimum Annual Aggregate Deductible: $6,905,219 or 95% of the first Monthly Aggregate Deductible amount times 12, whichever is greater.

Maximum Covered Expenses per Covered Person accumulating toward the Maximum Aggregate Benefit: $125,000

Aggregate Excess Loss Premium: $7.76 per Employee per month

Aggregate Terminal Liability Endorsement: ☐ Yes ☒ No
Aggregate Accommodation Endorsement: ☐ Yes ☒ No
Independent Review Organization Extended Liability Endorsement ☒ Yes ☐ No

Monthly Aggregate Factors:		
Covered Persons	Medical	Prescription Drugs
Employee	$ 959.50	Included
Employee + Spouse	$ 2,067.60	Included
Employee + Child(ren)	$ 1,616.85	Included
Employee + Family	$ 2,871.18	Included

It is understood and agreed by the undersigned that:

1. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
2. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 90 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 90 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
3. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
4. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
5. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.
6. The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned.
7. Other:
   - Except for allowed run-out claims paid by a prior administrator, any claims paid by an administrator or pharmacy benefit manager not listed herein will not be considered as a Covered Expense under this Excess Loss coverage.

- Rate Cap provision is included that will guarantee your Subsequent Policy Period beginning January 1, 2026 will not contain any new Specific Deductible greater than the group's standard Specific Deductible for any covered person. In addition, the Specific Monthly Premium Rate will not increase more than 50%. The Rate Cap will not apply if the Company determines there is a material change to the Policyholder's Plan, the Excess Loss Insurance Policy, or the composition of the group. Continuation of the Rate Cap will be assessed annually.
- Aggregate Factors are based on a 120 % corridor.

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Full Legal Name of Applicant: Board of Commissioners of Effingham County, Georgia

Signature of Authorized Person: Wesley M. Corbitt

Print Name: Wesley M. Corbitt Title: Chairman

Date: 12/03/2024

Signature of Agent or Broker: _____

Print Name of Agent or Broker: _____

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For applicants in Arkansas, Louisiana, New Mexico and Rhode Island:
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance, is guilty of a crime and may be subject to fines and confinement in prison.

For applicants in Colorado:
It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

For applicants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the application.

For applicants in Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For applicants in Kentucky, New Mexico, Ohio, and Pennsylvania:
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 subjects such person to criminal and civil penalties.

For applicants in Maine, Tennessee and Virginia:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.

For applicants in New Jersey:
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For applicants in all other states:
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefits.