

QBE A&H
123 Pleasant Street, 3rd Floor
Marblehead, MA 01945
Toll Free: 800.742.9279
qbeah.com



November 30, 2023

Cameron Dillion
Avant Specialty Benefits
12712 Park Central Drive Suite 100
Dallas, TX 75251

Dear Cameron,

Re:	Policy Issuance
Policyholder:	Town of Prosper, January 01, 2024
Policy Number:	LGS02268-24

Thank you for renewing coverage with QBE Insurance Corporation. We are pleased to have the opportunity to continue to service your client during the upcoming plan year.

Enclosed please find the appropriate renewal documents for completion. In order to bind coverage, the following requirements are needed.

- Signed and completed Application for Excess Loss Policy
- First month's renewal premium: (Specific)\$ 60,673.76 + (Aggregate)\$1,917.00 = \$62,590.76 is due within 30 days of effective date.
- ACH Claims Reimbursement Authorization form for completion; Provides faster claim reimbursement payment processing time, convenience, and security (if interested, please have this form completed and return).
- State Required Licensing: The signing agent must be licensed in the state where the prospective client is located, in the producer's resident state, and will need to be appointed with QBE where required.
- Signed Master Plan Document: If a new Plan Document is being drafted ensure it states all the provisions of the plan and delineates the various responsibilities for financing the plan, the eligibility, and all the other aspects of the plan (summary descriptions and certificates alone are not acceptable). If there have been no changes to the document on file with QBE, please provide written confirmation and ensure we have any Amendments not previously sent submitted.

The following Endorsement(s) modify the Excess Loss Policy and will be provided upon Policy Issuance.

- Advance Reimbursement Endorsement
- Amendatory Endorsement
- Plan Mirror Endorsement
- Rate Stabilization Endorsement **(50%)**
- Texas Endorsement

Please review the application and advise your underwriter of any requested changes prior to the client's signature. We will promptly re-issue the paperwork with any necessary changes.

Also enclosed is the Premium & Enrollment statement. Premium is due on the first of every month. Please note that premium must be remitted directly to the PO BOX address listed on the Premium & Enrollment statement. A completed copy of this statement should be remitted with each payment.

We appreciate your business partnership and the opportunity to service the needs of our mutual client. Please do not hesitate in contacting us with any questions or concerns.

Regards,

A handwritten signature in dark ink, appearing to read 'Jared Allard', is positioned above the typed name.

Account Manager
QBE A&H

Cc: Jared Allard



QBE INSURANCE CORPORATION
STATE OF DOMICILE: PENNSYLVANIA

APPLICATION FOR EXCESS LOSS INSURANCE POLICY (TEXAS)

Policy Number: **LGS02268-24**

1. Full legal name of Policyholder: **Town of Prosper** Tax ID Number: **75-6000642**
(as it will appear in the Policy)
2. Principal Office Address: **200 S. Main Street** **Prosper,** **TX** **75078**
(street) (city) (state) (zip)
3. Contact Person: **James Edwards** Email: **jedwards@prospertx.gov**
4. Nature of Business: **9111-Executive Offices**
5. If Employee Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:
6. Full name of Your Employee Benefit Plan:
A copy of Your Employee Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application.
7. Effective Date: **January 01, 2024**
8. Endorsements:

Advance Reimbursement Endorsement	AH-MSL-5013
Amendatory Endorsement	AH-MSL-5002
Plan Mirroring Endorsement	AH-MSL-5003
Rate Stabilization Endorsement	AH-MSL-5005
Texas Endorsement	AH-MSL-5010-TX
9. N/A
10. Your Designated Third Party Administrator (for purpose of claims administration under Your Employee Benefit Plan):

Name:	UMR
Address:	115 W. Wausau Avenue
City, State, Zip:	Wausau, WI 54401
Telephone:	(800) 992-8354
11. Your broker/agent of record:

Name:	Avant Specialty Benefits
Address:	12712 Park Central Drive Suite 100
City, State, Zip:	Dallas, TX 75251

12. Your PPO Network is: **UHC - Choice Plus**
13. Your Utilization Review Provider is: **UMR**
14. Eligible for coverage:
Retirees: Yes [] No **[X]** Late Entrants: Yes [] No **[X]**

15. Estimated Covered Units:
Covered Unit Description Units
Composite **284**

16. Initial premium deposit accompanying this Application:
(Specific)\$60,673.76 + (Aggregate)\$1,917.00 = \$62,590.76

17. **COVERAGES**

The Coverage shown applies only during the Policy Period from **January 01, 2024** (Effective Date) through **December 31, 2024** (Expiration Date) and is further subject to all the provisions of the Policy.

A. **SPECIFIC EXCESS LOSS COVERAGE** **[X]** Yes, included [] No, not included

- 1) Coverage to be included (not included unless checked):

[X] Medical **[X]** Prescription Drugs

- 2) Specific Attachment Point: **\$100,000.00.**
Per Covered Person.

- 3) Aggregating Specific Deductible: **\$0**
N/A

- 4) Specific Policy Period Maximum Reimbursement **Unlimited upon satisfaction of Specific Attachment Point** per Covered Person.

- 5) Basis of Specific Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from **January 01, 2019** through **December 31, 2024**
and paid from **January 01, 2024** through **December 31, 2024.**

Run-Out Period: 0 days

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
N/A per Covered Person
N/A for all Covered Persons combined

- 6) Premium Rates (per month):
Covered Unit Description Amount
Composite: **284** **\$213.64**

- 7) Estimated Annual Specific Premium: **\$728,085.00.**

B. **AGGREGATE EXCESS LOSS INSURANCE** **[X]** Yes, Included [] No, not included

- 1) Coverage to be included (not included unless checked):
[X] Medical **[X]** Prescription Drugs

- 2) Monthly Aggregate Factor:

Covered Unit Description	Total	Medical	Prescription Drugs
Employee:	<u>\$1,222.03</u>	<u>X</u>	<u>X</u>

- 3) Estimated Annual Aggregate Attachment Point: **\$4,164,678.24**

- 4) Minimum Annual Aggregate Attachment Point Percentage: **100%**
- 5) Estimated Minimum Annual Aggregate Attachment Point: **\$4,164,678.24 (Estimated)**
- 6) Individual Claim Limit **\$100,000.00**
Per Covered Person.
- 7) Aggregate Policy Period Maximum Reimbursement (per Policy Period): **\$1,000,000.00**
- 8) Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from **January 01, 2019** through **December 31, 2024**
and paid from **January 01, 2024** through **December 31, 2024**.
- Run-Out Period: 0 days
- Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
N/A per Covered Person
N/A for all Covered Persons combined
- 9) Premium Rates (per month):
- | Covered Unit Description | Amount |
|-----------------------------------|----------------------|
| <u>Aggregate Composite</u> | <u>\$6.75</u> |
- 10) Estimated Annual Aggregate Premium: **\$23,004.00.**

18. Special Limitations and Additional Information: **N/A**

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in the Application. You represent that You have formed Your Employee Benefit Plan in compliance with all applicable state and federal laws. It is agreed that the statements in the Application or in any materials submitted with this Application or attached to it, including all disclosure information, are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, We will have the right to revise the premium rates, factors, terms or conditions as of the Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and claims, if any, will be forfeited.

THIS APPLICATION DOES NOT BIND COVERAGE. Upon approval of the Application, the Policy evidencing that the coverage is in force will be issued by Us. Coverage will commence on the Effective Date set forth in the Policy. This Application will attach to and form part of the Policy.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, submits an application for insurance or makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud. (Policyholders located in AL, AR, CA, CO, DC, FL, KS, KY, LA, ME, MD, NJ, NM, NY, OH, OK, PA, RI, TN, VA, WA and WV must read the Fraud Warning applicable to their state.)

ACCEPTED BY THE POLICYHOLDER:

Signed at _____

Policyholder (correct legal name)

Date _____

By (Officer's signature and title)

(Print Name)

Signature Broker/Agent of Record

(Print Name)

ACCEPTED BY THE COMPANY:

Signed at **Marblehead, Massachusetts**

On behalf of the Company

Date _____

Tara Krauss, Head of A&H
By (Officer's name and title)

NOTICE TO ALABAMA APPLICANTS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

NOTICE TO ARKANSAS APPLICANTS: 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.

NOTICE TO CALIFORNIA APPLICANTS: The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by the insurer.

NOTICE TO COLORADO APPLICANTS: 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.

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: It is a crime to provide false or misleading information to an insurer for the 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 applicant.

NOTICE TO FLORIDA APPLICANTS: 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 in the third degree.

NOTICE TO KANSAS APPLICANTS: Any person who commits a fraudulent insurance act is guilty of a crime and may be subject to restitution, fines and confinement in prison. A fraudulent insurance act means an act committed by any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer or insurance agent or broker, any written, electronic, electronic impulse, facsimile, magnetic, oral or telephonic communication or statement as part of, or in support of, an application for insurance, or the rating of an insurance policy, or a claim for payment or other benefit under an insurance policy, which such person knows to contain materially false information concerning any material fact thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

NOTICE TO KENTUCKY APPLICANTS: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance 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.

NOTICE TO LOUISIANA & WEST VIRGINIA APPLICANTS: 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.

NOTICE TO MAINE, TENNESSEE, VIRGINIA & WASHINGTON APPLICANTS: 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.

NOTICE TO MARYLAND APPLICANTS: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE TO NEW JERSEY APPLICANTS: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NOTICE TO NEW MEXICO APPLICANTS: 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 CIVIL FINES AND CRIMINAL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: 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.

NOTICE TO OHIO APPLICANTS: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: Any person, who knowingly and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

NOTICE TO PENNSYLVANIA APPLICANTS: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any fact 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.

NOTICE TO RHODE ISLAND APPLICANTS: 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.