FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway
Kansas City, Missouri 64111

APPLICATION FOR EXCESS LOSS REIMBURSEMENT INSURANCE

GENERAL INFORMATION

1. Full Legal Name of Applicant: McKinney City of
   Address of Applicant: 314 South Chestnut Annex B, Suite 101
   City: McKinney State: TX Zip Code: 75069
2. Type of Entity:
   - [ ] Corporation
   - [ ] Labor Union
   - [ ] Partnership
   - [ ] Association
   - [ ] Limited Liability Co.
   - [ ] Trusteeship
   - [ ] Proprietorship
   - [X] Other: Municipality
3. Requested Effective Date: 01/01/2017
4. Other Locations:
5. Primary Contact at Applicant:
6. Full Legal Name of Subsidiary or Affiliated Companies to be included:
   Address:
   City: State: Zip Code:
7. Nature of Applicant's Business: General Government, NEC SIC Code: 9199
8. Full Name of Applicant's Plan: City of McKinney Medical Benefit Plan
   (A signed copy of such Plan must be attached to this Application.)
9. Name and Address of Plan Administrator or Third Party Administrator: Allegiance Benefit Plan Management, Inc
   Address: 2806 S Garfield St PO Box 3018
   City: Missoula State: MT Zip Code: 59801
   Social Security No. or Tax ID: Phone Number: (406)532-3501
10. Name and Address of Writing Agent: Eric D. Smith
    (Attach a current copy of license(s) if not on file.)
    Address: 906 Shady Lane
    City: Southlake State: TX Zip Code: 76092
    Social Security No. or Tax ID: Phone Number:
11. Estimated initial enrollment:

Employee/Member	875	Family	
Employee/Member + Spouse		Employee/Member + 1	
Employee/Member + Child(ren)		Dependent	
Employee/Member (Composite)			

12. Other Covered Persons included in your Plan:

	Yes	No	Covered Units
Retired Employee/Member	X		
COBRA Beneficiaries	X		
Disabled Persons	X		
Other			

13. Actively At Work Limitation: Waived [X] Applied [ ]
14. Deposit Premium: 77,657.00

SPECIFIC EXCESS LOSS INSURANCE: [X] **Yes** [ ] **No**

1. Plan Benefit Payments included in Your Plan to be covered by Specific Excess Loss Insurance:
   [X] Medical [X] Prescription Drug Expenses [ ] Other(s) ______
   [ ] Dental [ ] Vision
2. Contract Basis: 15/12 Covered Expenses Incurred from 10/01/2016 through 12/31/2017
   Paid from 01/01/2017 through 12/31/2017
3. Run-in Period claims Incurred prior to the Effective Date will be limited to: $ N/A
4. Specific Deductible (per Covered Person): $ 150,000
   Specific Deductible/Contract Basis for the following Covered Persons:
5. Specific Reimbursement Maximum per Contract Period: $ Unlimited
   (per Covered Person excess of Specific Deductible)
6. Specific Percentage Reimbursable (excess of Specific Deductible): 100%
7. Aggregating Specific Deductible: [ ] Yes [X] No
   If Yes, the Aggregating Specific Deductible is: $ N/A
8. Terminal Specific Liability: [ ] Yes [X] No
   If Yes, the Monthly Terminal Specific Liability Premium (per Covered Person): $ N/A
9. Specific Monthly Premium Rates:

Employee/Member	$ 85.00
Family	$
Employee/Member + Spouse	$
Employee/Member + Child(ren)	$
Employee/Member + 1	$
Dependent	$
Employee/Member (Composite)	$

AGGREGATE EXCESS LOSS INSURANCE: [X] **Yes** [ ] **No**

1. Plan Benefit Payments included in Your Plan to be covered by Aggregate Excess Loss Insurance:
   [X] Medical [X] Prescription Drug Expenses [ ] Other(s) ______
   [ ] Dental [ ] Vision
2. Contract Basis: 15/12 Covered Expenses Incurred from 10/01/2016 through 12/31/2017
   Paid from 01/01/2017 through 12/31/2017
3. Run-in Period claims Incurred prior to the Effective Date will be limited to: $ N/A
4. Minimum Aggregate Annual Deductible: $ 14,693,175
5. Aggregate Reimbursement Maximum (excess of Aggregate Annual Deductible): $ 1,000,000
6. Aggregate Percentage Reimbursable (excess of Aggregate Annual Deductible): 100%
7. Aggregate Monthly Factor(s):

	Medical	Dental	Vision	Prescription Drug	Other
Employee/Member	$ 1,399.35	$	$	$	$
Family	$	$	$	$	$
Employee/Member + 1	$	$	$	$	$
Employee/Member + Spouse	$	$	$	$	$
Employee/Member + Child(ren)	$	$	$	$	$
Dependent(s)	$	$	$	$	$
Employee/Member (Composite)	$	$	$	$	$

8. Loss Limit (per Covered Person): $ 150,000
9. Terminal Aggregate Liability Option: [ ] Yes [X] No
   If Yes, Monthly Terminal Aggregate Liability Premium (per Covered Person): $ N/A
10. Monthly Aggregate Accommodation Option: [ ] Yes [X] No
    If Yes, Monthly Aggregate Accommodation Premium (per Covered Person): $ N/A
11. Monthly Aggregate Premium Rate (per Covered Person): $ 3.32

MEDICAL DATA

The Company will rely on the data below to assist in approving the Application and underwriting the Contract. Note that without the Company's review and approval of each risk, the Applicant's Losses will not be reimbursable under the Excess Loss Reimbursement Contract; therefore, please answer the following questions:

1. Has an eligible employee/member or dependent received or is such individual expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? ☐ Yes ☐ No
2. Will any former employee/member or dependent be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? ☐ Yes ☐ No

If Yes to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign and date a separate sheet if needed):

Name: ______________ DOB: ________ Sex: ☐ Male ☐ Female Status: ________
(Ee/Mbr, Dep, COBRA, Retiree)

Diagnosis: *****SEE ATTACHED SIGNED LARGE CLAIM REVIEW ANALYSIS*****

Prognosis: ______________

Amount of Claim(s): ______________

3. Are expected benefits available from the prior insurer for presently disabled eligible employees/ members and/or dependents? ☐ Yes ☐ No
4. Are any eligible employees/members or dependents presently disabled or confined in a hospital or similar facility? ☐ Yes ☐ No

Please explain any "Yes" answers to questions 3 or 4 (Please attach, sign and date a separate sheet if needed):
*****SEE ATTACHED SIGNED LARGE CLAIM REVIEW ANALYSIS*****

SPECIAL CONDITIONS/LIMITATIONS:

This proposal assumes that the employer will use the current plan design through the Cigna network.

DISCLOSURE

The Excess Loss Reimbursement Contract Applicant Disclosure Statement must be received no earlier than 15 days prior to the effective date and no later than 15 days after the effective date. The Company reserves the right to adjust the rates, factors, deductibles and/or Special Limitations based upon information contained therein.

SIGNATURE

Application is hereby made for Specific and/or Aggregate Excess Loss Insurance through Fidelity Security Life Insurance Company ("Company"). This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

It is understood and agreed by the Applicant that:

1. the Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan;

2. the Plan Administrator or Third Party Administrator retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent;

3. all documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within 90 days of the Effective Date;

4. the Company will evaluate the Applicant's risk, and may require adjustments of rates, factors, deductibles and/or Special Limitations to accommodate for abnormal risks;

5. premiums are not considered paid until the premium check or transfer is received by the Company and at the rates set forth in the Schedule;

6. this Application will be attached to and made a part of any Excess Loss Reimbursement Contract issued by the Company in connection with this Application;

7. the Applicant's Plan Document shall be the basis of any Excess Loss Insurance Reimbursement provided by the Company and such Plan Document conforms with applicable state and federal laws;

8. any reimbursement under the Excess Loss Reimbursement Contract provided by the Company shall be based on eligible Plan Benefits Paid in accordance with the Plan Document;

9. claims under the Plan Document for any employee/member who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such employee/member returns to active, full-time employment for at least one full working day;

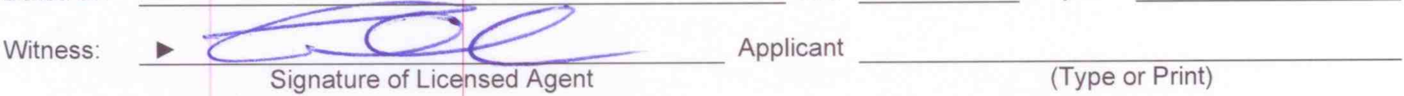
10. unless otherwise indicated above, claims under the Plan Document for any Covered Person who is confined in a medical facility on the Effective Date of the Excess Loss Reimbursement Contract will not be eligible for reimbursement under the Contract until such person is discharged from the hospital or similar facility; and

11. if there is any material change in the answers to the questions in this Application or the Excess Loss Reimbursement Contract Applicant Disclosure Statement before the Contract Effective Date, the Applicant must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

I represent that as of the date I signed this Application, all statements and answers recorded on this Application are true and complete and are made to obtain the insurance applied for and that the undersigned has the authority to bind the Applicant to the proposed Contract. These statements are to be considered representations and not warranties. Accordingly, this Application will be part of the Contract if accepted by the Company or its authorized representative.

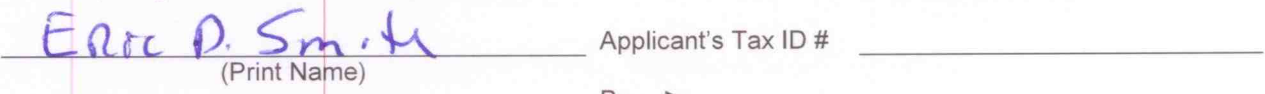
Any person who with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Dated at: ______________________ this __________ day of ______________



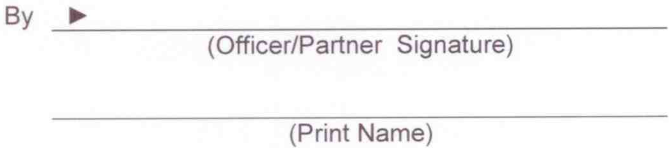
Witness: ► ______________________ Applicant ______________________

Signature of Licensed Agent (Type or Print)



______________________ Applicant's Tax ID # ______________________

(Print Name)



By ► ______________________

(Officer/Partner Signature)

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(Print Name)

Title: ______________________