HM LIFE INSURANCE COMPANY
HM INSURANCE GROUP

P.O. Box 535057
Pittsburgh, PA 15253-5057
Tel: 800-328-5433
Fax: 412-544-1246
hmig.com

HM Stop Loss
Application for Insurance

Please Type or Print – Must be completed in full.

Applicant Information

Full Legal Name of Group (*to appear on Policy*)		Key Contact Person	
Tax ID Number		Business Telephone Number	Fax Number
Email		Internet	
Address		City	State / Zip Code + 4
Delivery Address (*if different than above*)		City	State / Zip Code + 4
Nature of Business	SIC Code	☐ Corporation ☐ Partnership ☐ Government ☐ Other*: _____	

*If an Association, Trust or Charitable Organization, a copy of the bylaws and/or trust is required with the submission of the application. If a union, or if union employees are covered, a copy of the collective bargaining agreement is required with the submission of the application.

Affiliates to be insured? ☐ Yes* ☐ No *If "yes," complete the table below, attaching additional sheets if necessary.

AFFILIATE #1	Full Legal Name	Nature of Business	
Address	City	State	Zip Code
AFFILIATE #2	Full Legal Name	Nature of Business	
Address	City	State	Zip Code
AFFILIATE #3	Full Legal Name	Nature of Business	
Address	City	State	Zip Code

Third Party Administrator (TPA)

Full Legal Name of TPA			
Tax ID Number	Business Telephone Number	Fax Number	
Address	City	State	Zip Code + 4
Delivery Address (*if different than above*)	City	State	Zip Code + 4
Key Contact Person	Email	Internet	

Applicant's Initials: _____

Producer (*Agent/Broker*)				
Name		License Number(s) – *Please attach a copy, if not on file.*		
Tax ID Number	Business Telephone Number	Fax Number	Email	Internet
Address		City	State	Zip Code + 4
Requested Effective Date				
Estimated Initial Enrollment:	Single: _____	Family: _____	Total: _____	

Premium Deposit of $_____ included. Estimated 1st month's premium must be attached to this application. The Premium Deposit will be applied to the first premium when due. Make check payable to HM Life Insurance Company. Do not make the check payable to the agent or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

Fraud Notice (*Please read carefully*)

For your protection Arizona law requires the following statement to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal or civil penalties." Any person 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.

APPLICANT UNDERSTANDS AND AGREES THAT

The stop loss insurance requested and requested effective date must be approved by HM Life Insurance Company as under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of the first month's premium, final census, Claim Information, and any other information requested in connection with this application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that HM Life Insurance Company, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of Disclosure, Claim Information and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. Should subsequent information become known which, if known as of the date specified by HM Life Insurance Company, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within 60 days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the data, including Disclosure, census and Claim Information, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for HM Life Insurance Company's approval of the requested stop loss insurance.

Applicant's Initials: _____

APPLICANT UNDERSTANDS AND AGREES THAT (continued)

Printed Name of Applicant's Authorized Representative

Signature of Applicant's Authorized Representative | Date | Title

Signature of Producer | Print Name of Producer

Applicant's Initials: _____