The Union Labor Life Insurance Company

Stop Loss Claims // TPA Administration Guide
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I. INTRODUCTION

The Union Labor Life Insurance Company (Ullico) is providing this document as a reference guide for our clients and their designated Third Party Administrators (TPA), who are responsible for the administration of the Plans’ Specific and Aggregate Stop Loss claims. We highly encourage the TPA personnel to become familiar with the requirements and processes outlined on this guide to facilitate an efficient claims handling process for the benefit of our mutual client, the Policyholder.

The purpose of this guide is to provide administrative instructions for proper and timely submissions of Notifications of potentially catastrophic claims; and Specific and Aggregate claims. This guide also aims to provide guidance to our clients and their designated TPA on how to utilize the services of our cost-containment vendors.

Please refer to your Stop Loss Policy and to this Guide when you have questions about your coverage. The Language contained in this document is provided as a guide and in no way binds The Union Labor Life Insurance Company (Ullico) or Policyholder in any matter that differs from the coverage expressly stated within the Policy. In the event that there is any conflict between this Guide and the Policy, the language of the Policy will take precedence and control.

If you need additional information, please contact us at:

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Stop Loss Claims Unit
Toll Free Number: 1-800-328-5837
Fax Number: 1-202-682-6920
Email: StopLossClaims@ullico.com

Our hours of operation are Monday to Friday from 8:00 a.m. to 4:30 p.m., Eastern time.

You may also visit us at the web at www.ullico.com.
II. SPECIFIC STOP LOSS CLAIM NOTIFICATION

Early identification and notification of potential catastrophic claims are essential to providing quality claims management. This will allow implementation of large case management and other cost containment strategies, which can be mutually beneficial to all parties by preserving Plan Benefits and saving claims dollars.

Potential Large Stop Loss Claim Notification

The Union Labor Life Insurance Company requires that potential large claim information identified through the TPA, Broker, or any Utilization Review vendors is submitted directly and promptly to The Union Labor Life Insurance Company. Such notification must be made for an individual claimant at the earliest of:

a. Attaining 50% of their Specific Deductible or $100,000, whichever is lesser;
b. Identified with conditions or diagnosis listed in our Trigger Diagnosis Listing; or
c. Has been identified through pre-certification of a hospital confinement or other manner with a potentially catastrophic diagnosis or is expected to be under Large Case Management

All notices should be submitted in writing. The Stop Loss Notification and Initial Claim Form is available for your use. Please refer to the Stop Loss Forms section of this guide. If The Union Labor Life Insurance Company notification form is not used, an approved written or electronic notification must include the following information:

- Policyholder name
- Employee name, Social Security or unique member identification number
- Plan number (or type)
- Claimant’s name & relationship to employee
- Diagnosis
- Prognosis
- On-set date of diagnosis or condition
- Specific deductible
- Total amount of self-funded claims paid to date
- Any pertinent information regarding claimant’s condition (pending transplant, hospital confinement, etc.) and...
- Name and phone numbers for any attending physicians and/or nurse case manager
- Type of notification (i.e. Trigger Diagnosis, 50% Notice, etc.)

50% Notifications

Notification must be given monthly to The Union Labor Life Insurance Company when the total amount of Plan Benefits paid on a Covered Person equals or exceeds 50% of the specific deductible or $100,000, whichever is lesser. This notification will allow The Union Labor Life Insurance Company Risk Assessment team to review the cost saving policies and procedures that are being applied by the TPA. This will also allow The Union Labor Life Insurance Company to properly set appropriate reserves in the event that an actual claim occurs. Failure to give prompt notice, as defined by the Stop Loss Policy, may result in an adjustment of the reimbursement to the Plan Sponsor, if any, to reflect any savings The Union Labor Life Insurance Company could have obtained had prompt 50% notification been given.
**Trigger Diagnosis Notification**

A Trigger Diagnosis is a condition which tends to be chronic in nature, requiring extensive on-going treatment, hospitalization, case management and/or high cost medications. These types of conditions have the potential for high dollar claims. The TPA must give immediate notification to The Union Labor Life Insurance Company as soon as a catastrophic diagnosis on a covered employee or eligible dependent has been identified.

The Union Labor Life Insurance Company adheres to the Self-Insurance Institute of American (SIIA) Endorsed ICD-10 (October 2015) and ICD-9 (September 2005) Code Lists and those identified by the Stop Loss Carrier, for identifying catastrophic diagnoses.

Similarly, this notification will allow The Union Labor Life Insurance Company to review the cost saving policies and procedures that are being applied by the TPA and assist them by providing cost containment tools as deemed necessary. This will also allow The Union Labor Life Insurance Company to set appropriate reserves in the event that an actual claim occurs. Failure to give prompt notice, as defined by the Stop Loss Policy, may result in an adjustment of the reimbursement to the Plan Sponsor, if any, reflect any savings The Union Labor Life Insurance Company could have obtained had prompt Trigger Diagnosis notification been given.

**Large Case Management Notification**

The Union Labor Life Insurance Company must be notified immediately of any known claimant who is currently or expecting to be under the care of the Plan’s designated Case Management firm or through the pre-certification of a hospital confinement, was identified with a potentially catastrophic diagnosis or is expected to be under Large Case Management.
TRIGGER DIAGNOSIS AND POTENTIAL CATASTROPHIC CASES LIST

The specific diagnoses listed below are key trigger indications of potentially catastrophic losses and should be referred to Ullico. The following should also be explored for potential Case Management.

- Transplants - liver, renal, heart, lung, pancreas, bone marrow and any combinations
- Hospitalization request of fourteen (14) days or greater
- Trauma/Multiple Injuries
- Request for transfer to a rehabilitation facility
- Hyperalimentation (TPN)
- Home IV antibiotic therapy
- High Risk Pregnancy (Multiple Births)
- Initiation of hemodialysis
- Home Health Care request that is greater than 20 days

ICD-9 CODE LISTS

<table>
<thead>
<tr>
<th>001-139</th>
<th>Infectious and Parasitic Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>038-038.9</td>
<td>Septicemia</td>
</tr>
<tr>
<td>042</td>
<td>AIDS / HIV</td>
</tr>
<tr>
<td>070-070.9</td>
<td>Viral Hepatitis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>140-239</th>
<th>Neoplasms</th>
</tr>
</thead>
<tbody>
<tr>
<td>140-149.9</td>
<td>Malignant Neoplasm of Lip, Major Salivary Glands, Gum, Mouth, Oropharynx, Nasopharynx, and/or Hypopharynx</td>
</tr>
<tr>
<td>150-150.9</td>
<td>Malignant Neoplasm of Esophagus</td>
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<tr>
<td>151-151.9</td>
<td>Malignant Neoplasm of Stomach</td>
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<tr>
<td>153-153.9</td>
<td>Malignant Neoplasm of Colon</td>
</tr>
<tr>
<td>154-154.8</td>
<td>Malignant Neoplasm of Rectum</td>
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<tr>
<td>155-155.2</td>
<td>Malignant Neoplasm of Liver</td>
</tr>
<tr>
<td>157-157.9</td>
<td>Malignant Neoplasm of Pancreas</td>
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<tr>
<td>161-161.9</td>
<td>Malignant Neoplasm of Larynx</td>
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<tr>
<td>162-162.9</td>
<td>Malignant Neoplasm of Lung</td>
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<tr>
<td>170-170.9</td>
<td>Malignant Neoplasm of Bone</td>
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<tr>
<td>174-174.9</td>
<td>Malignant Neoplasm of Female Breast</td>
</tr>
<tr>
<td>179-182.8</td>
<td>Malignant Neoplasm of Uterus or Cervix</td>
</tr>
<tr>
<td>183-183.9</td>
<td>Malignant Neoplasm of Ovary</td>
</tr>
<tr>
<td>185</td>
<td>Malignant Neoplasm of Prostate</td>
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<tr>
<td>186-186.9</td>
<td>Malignant Neoplasm of Testis</td>
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<tr>
<td>188-189.9</td>
<td>Malignant Neoplasm of Bladder, Kidney, Urinary</td>
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<tr>
<td>191-191.9</td>
<td>Malignant Neoplasm of Brain</td>
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<tr>
<td>192-192.9</td>
<td>Malignant Neoplasm of Nervous System</td>
</tr>
<tr>
<td>194-194.9</td>
<td>Malignant Neoplasm of Endocrine Glands</td>
</tr>
</tbody>
</table>

| 195-195.8  | Malignant Neoplasm of Other Ill- Defined Sites |
| 196-196.9  | Secondary Malignant Neo. Lymph Nodes |
| 197-197.8  | Secondary Malignant Neo. Respy and Digestive Systems |
| 198-198.89 | Secondary Malignant Neo. Other Specified Sites |
| 200-208.9  | Lymphoma and/or Leukemia           |
| 235        | Neoplasm Uncertain Behavior        |
| 239.2      | Neoplasm Unspecified Nature – Bone, Skin |

<table>
<thead>
<tr>
<th>240-279</th>
<th>Endocrine, Nutritional, Metabolic, Immunity</th>
</tr>
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<tbody>
<tr>
<td>250-250.9</td>
<td>Diabetes</td>
</tr>
<tr>
<td>277.0</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>278.0</td>
<td>Obesity/Hyperaliment</td>
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<table>
<thead>
<tr>
<th>280-289</th>
<th>Diseases of the Blood and Blood-Forming Organs</th>
</tr>
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<tbody>
<tr>
<td>282.6</td>
<td>Sickle-Cell Anemia</td>
</tr>
<tr>
<td>284.9</td>
<td>Aplastic Anemia NOS</td>
</tr>
<tr>
<td>286-286.9</td>
<td>Coagulation Defects and/or Hemophilia</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>320-389</th>
<th>Diseases of the Nervous System and Sense Organs</th>
</tr>
</thead>
<tbody>
<tr>
<td>330</td>
<td>Cerebral degenerations</td>
</tr>
<tr>
<td>344.0-344.09</td>
<td>Quadriplegia and Quadriparesis</td>
</tr>
<tr>
<td>331.0-331.9</td>
<td>Reye’s Syndrome</td>
</tr>
<tr>
<td>344.1</td>
<td>Paraplegia</td>
</tr>
</tbody>
</table>
320-389 Diseases of the Nervous System and Sense Organs (cont’d)
348.0-348.9 Encephalopathy
357, 358 Neuropathy / Myasthenia Gravis

390-459 Diseases of the Circulatory System
410-410.9 Acute Myocardial Infarction
411-411.89 Acute and Subacute Ischemic Heart Disease
414-414.05 Coronary Atherosclerosis (ASHD)
415-415.19 Acute Pulmonary Heart Disease
416-416.9 Chronic Pulmonary Heart Disease
417.1 Aneurysm of Pulmonary Artery
421-421.9 Acute and Subacute Endocarditis
424-424.9 Valve Disorders
425-425.9 Cardiomyopathy
426-426.9 Conduction Disorders
427-427.9 Cardiac Dysrhythmias
428-428.9 Heart Failure
430, 431 Subarachnoid / Intracerebral Hemorrhage
434.9 Occlusion of Cerebral Arteries
436 Acute Cerebrovascular Accident (CVA)
440-441.9 Atherosclerosis / Aortic Aneurysm

460-519 Diseases of the Respiratory System
480-486 Pneumonia
490-496 Chronic Obstructive Pulmonary Disease (COPD), etc.
515 Postinflammatory Pulmonary Fibrosis
518-518.89 Pulmonary Collapse and/or Respiratory Failure

520-579 Diseases of the Digestive System
555-555.9 Regional Enteritis (Crohn’s Disease)
560.0-560.9 Intestinal Obstruction
562.1 Diverticulitis of Colon
567-567.9 Peritonitis
569.0-569.9 Other Disorders of Intestine
570-571.9 Liver Diseases and Cirrhosis
572.8 Other Sequela of Chronic Liver Disease
573-573.9 Other Liver Disorders
577-577.9 Pancreas Diseases
578-578.9 Gastrointestinal Hemorrhage

580-629 Diseases of the Genitourinary System
584-584.9 Acute Renal Failure
585 Chronic Renal Failure

586 Renal Failure, Unspecified
588 Disorders resulting from impaired renal function
592 Calculus of Kidney & Ureter

630-677 Complications of Pregnancy, Childbirth
641.1 Placenta Previa
642.5-642.7 Eclampsia, pre-eclampsia
644.0-644.2 Premature Labor
648.0 Gestational Diabetes
651 Multiple Gestation
654.5 Cervical Incompetence

710-739 Diseases of the Musculoskeletal System and Connective Tissue
715.0-715.9 Osteoarthritis
721.3 Lumbar Spondylosis
722.0-722.9 Intervertebral Disc Disorders
730-730.9 Osteomyelitis and/or Periostitis
737.3 Kyphoscoliosis and scoliosis

740-759 Congenital Anomalies
747.2 Aortic Atresia / Stenosis
751.6 Biliary Atresia
759-759.9 Other and Unspecified Congenital Anomalies

760-779 Conditions Originating in the Perinatal Period
765-765.1 Prematurity
769 Respiratory Distress Syndrome
770.0-770.9 Other Respiratory Conditions of Newborn

780-799 Symptoms, Signs, and Ill-Defined Conditions
785-785.9 Symptoms Involving Cardiovascular System
786.5-786.59 Chest Pain

800-999 Injury and Poisoning
800-804.9 Fracture of Skull
805-805.9 Fracture of Vertebral Column
806-806.9 Fracture of Vertebral Column with Spinal Cord Injury
828-828.1 Multiple Fractures
853-854.1 Intracranial Injury
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>952-952.9</td>
<td>Spinal Cord Injury</td>
</tr>
<tr>
<td>996-997.0</td>
<td>Complications peculiar to certain specified conditions</td>
</tr>
<tr>
<td>V23</td>
<td>Supervision of High Risk Pregnancy</td>
</tr>
<tr>
<td>V42 – V58.9</td>
<td>Transplants, etc</td>
</tr>
</tbody>
</table>
## ICD-10 CODE LIST

### A00-B99 Certain Infectious and Parasitic Disease
- **A40** Streptococcal sepsis
- **A41** Other Sepsis
- **B15-B19** Viral hepatitis
- **B20** Human immunodeficiency virus [HIV] disease

### C00-D49 Neoplasms
- **C00-C96** Malignant neoplasms
- **D46** Myelodysplastic syndromes

### D50-D89 Diseases of the Blood and Blood-forming Organs & Disorders Involving the Immune Mechanism
- **D57** Sickle-cell disorders
- **D59** Acquired hemolytic anemia
- **D60-D64** Aplastic and other anemias
- **D65-D69** Coagulation defects, purpura and other hemorrhagic conditions
- **D70-D77** Other diseases of blood and blood-forming organs
- **D80-D89** Certain disorders involving the immune mechanism

### E00-E89 Endocrine, nutritional and metabolic diseases
- **E10-E13** Diabetes mellitus
- **E15-E16** Other disorders of glucose regulation and pancreatic internal secretion E65-E68 Obesity and other hyper alimentation
- **E70-E89** Metabolic disorders

### F01-F99 Mental, Behavioral and Neurodevelopmental disorders
- **F10.1** Alcohol Abuse
- **F11.1** Opioid Abuse
- **F20** Schizophrenia
- **F31** Bipolar Disorder
- **F32.3** Major depressive disorder, single episode, severe with psychotic feature
- **F33.1-F33.3** Major Depressive Disorder, recurrent
- **F84.0** Autistic Disorder
- **F84.2** Rett's Syndrome
- **F84.5** Asperger's syndrome

### G00-99 Diseases of the nervous system
- **G00** Bacterial Meningitis
- **G04** Encephalitis Myelitis and Encephalomyelitis.
- **G06-G07** Intracranial and intraspinal abscess and granuloma
- **G12.21** Amyotrophic Lateral Sclerosis
- **G35** Multiple Sclerosis
- **G36** Other Acute Disseminated Demyelination
- **G37** Other Demyelinating disease of central nervous system
- **G82.5** Quadraplegia
- **G83.4** Cauda Equina Syndrome
- **G92** Toxic Encephalopathy
- **G93.1** Anoxic Brain Injury

### I00-I99 Diseases of Circulatory System
- **I20** Angina Pectoris
- **I21.09-I22** Acute myocardial infarction
- **I24** Acute and Subacute Ischemic Heart Disease
- **I25** Chronic ischemic heart disease
- **I26** Pulmonary embolism
- **I27** Other pulmonary heart disease
- **I28** Other diseases of pulmonary vessels
- **I33** Acute & Subacute Endocarditis
- **I34-I38** Heart Valve Disorders
- **I42-I43** Cardiomyopathy
- **I44-I45** Conduction Disorders
- **I46** Cardiac Arrest
- **I47-I49** Cardiac Dysrhythmias
- **I50** Heart Failure
- **I60-161** Subarachnoid Hemorrhage/Intercerebral Hemorrhage
- **I63** Cerebral infarction
- **I65.8-I66** Occlusion of Precerebral/Cerebral Arteries
- **I67** Other cerebrovascular disease
- **I70** Atherosclerosis / Aortic Aneurysm
**J00-J99  Diseases of Respiratory System**

- J00-J99  Diseases of Respiratory System
- J40-J44 Chronic Obstructive Pulmonary Disease (COPD)
- J84.10-J84.89 Postinflammatory Pulmonary Fibrosis
- J98.11-J98.4 Pulmonary Collapse / Respiratory Failure

**K00-K95  Diseases of Digestive System**

- K00-K95  Diseases of Digestive System
- K22 Esophageal obstruction
- K25-K28 Ulcers
- K31 Other diseases of stomach & duodenum
- K50 Crohn’s disease
- K51 Ulcerative colitis
- K55-K64 Diseases of intestine
- K65-K68 Diseases of peritoneum & retroperitoneum
- K70-K77 Diseases of liver
- K83 Diseases of biliary tract
- K85-K86 Diseases of pancreatitis
- K90-K95 Other diseases of digestive system/Complications of bariatric procedures

**M00-M99  Diseases of Musculoskeletal System & Connective Tissue**

- M00-M99  Diseases of Musculoskeletal System & Connective Tissue
- M15-M19 Osteoarthritis
- M32 Systemic lupus erythematosus
- M34 Systemic sclerosis
- M41 Scoliosis
- M43 Spondylolysis
- M50 Cervical disc disorders
- M51 Thoracic, thoracolumbar & lumbosacral intervertebral disc disorders
- M72.6 Necrotizing Fasciitis
- M86 Osteomyelitis

**N00-N99  Diseases of the Genitourinary System**

- N00-N01 Acute and Rapidly Progressive Nephritic Syndrome
- N03 Chronic Nephritic Syndrome
- N04 Nephrotic Syndrome
- N05-N07 Nephritis and Nephropathy
- N08 Glomerular Disorders classified elsewhere
- N17 Acute Kidney Failure
- N18 Chronic Kidney Disease (CKD)
- N19 Renal Failure, Unspecified

**O00-O9A  Pregnancy, childbirth and the puerperium**

- O00-O9A  Pregnancy, childbirth and the puerperium
- O09 High Risk Pregnancy
- O11 Pre-Existing Hypertension with Pre-Eclampsia
- O14-O15 Pre-Eclampsia and Eclampsia
- O30 Multiple Gestation
- O31 Other complications specific to Multiple Gestations

**P00-P96  Certain conditions originating in the perinatal period**

- P00-P96  Certain conditions originating in the perinatal period
- P07 Disorders of newborn related to short gestation and low birth weight
- P10-P15 Birth Trauma
- P19 Fetal distress
- P23-P28 Other respiratory conditions of newborn
- P29 Cardiovascular disorders originating in the perinatal period
- P36 Bacterial sepsis of newborn
- P52-P53 Intracranial hemorrhage of newborn
- P77 Necrotizing enterocolitis of newborn
- P91 Other disturbances of cerebral status newborn

**Q00-Q99  Congenital malformations, deformations and chromosomal abnormalities**

- Q00-Q99  Congenital malformations, deformations and chromosomal abnormalities
- Q00-Q07 Congenital malformations of the nervous system
- Q20-Q26 Congenital Cardiac malformations
- Q41-Q45 Congenital Anomalies of Digestive system
- Q85 Phakomatoses, not classified elsewhere
- Q87 Congenital malformation syndromes affecting multiple systems
- Q89 Other Congenital malformations

**R00-R99  Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified**

- R00-R99  Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified
- R07.1-R07.9 Chest Pain
- R40-R40.236 Coma
- R57-R58 Shock, Hemorrhage
- R65.2-R65.21 Severe sepsis
### S00-T88 Injury, Poisoning and Certain Other Consequences of External Causes

- **S02** Fracture of skull and facial bones
- **S06** Intracranial injury
- **S07** Crush injury to head
- **S08** Avulsion and traumatic amputation of part of head
- **S12-S13** Fracture and injuries of cervical vertebra and other parts of neck
- **S14.0-S14.15** Injury of nerves and spinal cord at neck level
- **S22.0** Fracture of thoracic vertebra
- **S24** Injury of nerves and spinal cord at thorax level
- **S25** Injury of blood vessels of thorax
- **S26** Injury of heart
- **S32.0-S32.2** Fracture of lumbar vertebra
- **S34** Injury of lumbar and sacral spinal cord and nerves
- **S35** Injury of blood vessels at abdomen, lower back and pelvis
- **S36-S37** Injury of intra-abdominal organs
- **S48** Traumatic amputation of shoulder and upper arm
- **S58** Traumatic amputation of elbow and forearm
- **S68.4-S68.7** Traumatic amputation of hand at wrist level
- **S78** Traumatic amputation of hip and thigh
- **S88** Traumatic amputation of lower leg
- **S98** Traumatic amputation of ankle and foot
- **T30-T32** Burns and corrosions of multiple body regions
- **T81.11-T81.12** Postprocedural cardiogenic and septic shock
- **T82** Complications of cardiac and vascular prosthetic devices, implants and grafts
- **T83-T85** Complications of prosthetic devices, implants and grafts
- **T86** Complications of transplanted organs and tissue
- **T87** Complications to reattachment and amputation

### Z00-Z99 Factors Influencing Health Status and Contact with Health Services

- **Z37.5-Z37.6** Multiple births
- **Z38.3-Z38.8** Multiple births
- **Z48-Z48.298** Encounter for aftercare following organ transplant
- **Z49** Encounter for care involving renal dialysis
- **Z94** Transplanted organ and tissue status
- **Z95** Presence of cardiac and vascular implants and grafts
- **Z98.85** Transplanted organ removal status
- **Z99.1** Dependence on respirator
- **Z99.2** Dependence on dialysis
In addition to the Trigger Diagnosis that were listed on the previous pages, the following specific procedures listed below are further indicators of potential catastrophic cases and should be referred to Ullico.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>CPT Code</th>
</tr>
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<tbody>
<tr>
<td>Craniotomy</td>
<td>61304 - 61305</td>
</tr>
<tr>
<td>Hyperbaric Oxygenation</td>
<td>99183</td>
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<tr>
<td>Plasmapheresis (Apheresis)</td>
<td>36520 - 36521</td>
</tr>
<tr>
<td>Laryngectomy/Radical Neck Dissection</td>
<td>31360 - 31382</td>
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<tr>
<td>Tracheostomy</td>
<td>31600 – 31605</td>
</tr>
<tr>
<td>Implant Cardiac Assist Device</td>
<td>92970</td>
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<tr>
<td>Hemodialysis</td>
<td>90935 – 90937</td>
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<tr>
<td>Pancreatectomy</td>
<td>48140 – 48146, 48150 – 48154</td>
</tr>
<tr>
<td>Ventilator patient greater than 4 days</td>
<td>94656 – 94657</td>
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<tr>
<td>Insertion shunt/fistula</td>
<td>36821</td>
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<tr>
<td>Gastric Bypass</td>
<td>43842 - 43843, 43846 – 43847</td>
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<tr>
<td>TPN (Total Parenteral Nutrition)</td>
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<tr>
<td>Transplants(^1)</td>
<td>Various</td>
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<tr>
<td>Bone Marrow Transplant</td>
<td>38240 – 38241</td>
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<td>Heart</td>
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<td>Heart – Lung</td>
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<td>Small Bowel</td>
<td>44135 - 44136</td>
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<td>Liver</td>
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<td>Lung (single)</td>
<td>32851 – 32852</td>
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<td>Lung (double)</td>
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<td>Pancreas</td>
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<td>Kidney</td>
<td>50360</td>
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</table>

\(^1\) The transplants that are listed above should be reported to Ullico immediately for cost containment review and strategies.
III. SPECIFIC CLAIM REIMBURSEMENT PROCESS

A Specific Stop Loss claim occurs when total PAID amount on Plan Benefits on behalf of a Covered Person exceeds the Specific Deductible. Such payment should be made within the time allowed following receipt of a clean claim and falls under Incurred and Paid period as described under the Stop Loss Policy terms.

For the purpose of claim filing, the Stop Loss Notification/Initial Claim and the Stop Loss Subsequent Claim Forms can be found in the Forms section of this document. Specific Stop Loss claims will be reviewed and a determination made within 30 calendar days from receipt of all required claim information.

TYPES OF SPECIFIC STOP LOSS CLAIMS

A. Initial Claim – The first claim submitted during the contract period on behalf of an eligible individual
B. Subsequent Claim – Also referred to as a Supplemental Claim, this is submitted during the contract period on behalf of an eligible individual, after reimbursement of the Initial Claim.

1. Initial Claim

Filing Guidelines

1. You can submit completed, signed and dated claim forms with all supporting documents:

   By mail to:
   
   The Union Labor Life Insurance Company
   8403 Colesville Road, Suite 1300
   Silver Spring, MD 20910
   Attention: Stop Loss Claims Unit

   By fax to: Fax Number: 1-202-682-6920

   Or via email to: StopLossClaims@ullico.com

2. Claim requests should be equal of greater than $1,000.00, unless filing for the final claim submission on behalf of an eligible individual.
3. Claim must be submitted to Ullico within ninety (90) days after the Plan Sponsor has paid eligible expense on behalf of the Covered Person. Any claims for reimbursement received by Ullico more than 90 days after the last date for which a claim can be reimbursed under the terms of the Excess Loss Contract, will be denied, unless the Plan Sponsor shows that timely submission was not possible, and that the Plan Sponsor made the submission as soon as possible. In no event will we reimburse claims submitted more than one (1) year after proof of loss was otherwise due. Consult your Stop Loss Policy for additional details.

4. Documentation Requirements:

1) The Union Labor Life Insurance Company’s Specific Stop Loss Claim Form (Notification/Initial or Subsequent Claim Form) – completed, signed and dated;

2) Eligibility Documentation:
   a. Copy of employee’s Enrollment Form(s), including the hire date and original effective date, and any enrollment changes;
   b. Documentation showing type of coverage elected and covered dependents;
   c. Proof showing satisfaction of Waiting Period;
   d. Documentation of accumulated and used Banked Hours;
   e. Documentation of Hours Worked;
   f. If disabled: Proof of how coverage was maintained while off work
   g. For COBRA participants: Copy of the COBRA notification, election form and proof of timely receipt of premium payments for all months;
   h. For Dependents: Other Insurance (COB) information
   i. For Plans that cover dependent children after age 26: Copy of proof of eligibility, as required in the Plan Document.

3) Claim Information:
   a. Copies of Explanation of Benefits (EOB’s) attached to:
   b. Standard medical bills:
      i. HCFA -1500 (Physicians and other professional providers);
      or
      ii. UB-04 (Hospitals, Facilities and other institutional providers) - with corresponding DAILY itemized bills for charges in excess of $100,000;
   c. Copies of checks if not part of the EOB’s;
   d. PPO Discount/Repricing sheets;
e. System-generated claim detail report containing the following information:

i. Employer/Group Name;
ii. Employee name;
iii. Claimant name;
iv. Provider Name;
v. Dates of Service;
vi. Payment information, including Amount Paid, Check numbers, Check Date, Status of Check
vii. Types of Service – CPT/Revenue Codes
viii. Diagnosis – ICD-9/ICD-10
ix. Total Billed Amount
x. Discounts [PPO, Negotiated, or Contractual]
xi. Ineligible or Denied benefits with reason for denial
xii. Deductibles, Co-pays and co-insurances
xiii. Coordination of benefit
xiv. Denied or ineligible amount
xv. Total payment line calculation

4) Other applicable Miscellaneous Information/Documentation:

a. Complete accident details, including how, when and where the accident occurred;

b. Police Report for Motor Vehicle Accidents or for any services for which a Law Enforcement Agency is involved;

c. Competed and Signed Subrogation and Right of Recovery Reimbursement Agreement if charges were incurred as a result of a third party liability;

d. Coordination of Benefits (COB) documentation;

e. Medical Management Reports including, but not limited to the following, as applicable:

i. Pre-Certification documentation

ii. Case Management notes

iii. Medical Records/Operative Notes (including hospital admission and discharge summaries)
2. Subsequent Reimbursement Claims

Filing Guidelines
The requirements for Subsequent Claims are the same as those of the Initial Claim. However, if there has been no changes since the Initial (or last Subsequent) Claim submission, items a - g listed under the “Eligibility Documentation” described under the “Documentation Requirements” are waived.

ADVANCED FUNDING REQUESTS

Funding a large catastrophic claim may present a hardship to some Plans who may not have the cash flow available to cover an extremely large provider bill. To alleviate such hardship, The Union Labor Life Insurance Company offers an Advance Funding option to provide cash-flow assistance. The Advance Funding option permits a self-funded Plan to apply for Specific Stop Loss reimbursement before the Plan’s claim is fully funded.

A written notice of Specific Advanced Funding request must be received by The Union Labor Life Insurance Company no more than thirty (30) days prior to the end of the Specific Benefit Period. A fully completed and signed Stop Loss Notification/Initial Claim or the Stop Loss Subsequent Claim Form is required for each Advanced Funding request, include the amount of the Specific Advance Funding that is being requested, and should be in the amounts equal to or greater than $1,000.

The Union Labor Life Insurance Company requires that the following conditions are satisfied when filing a claim for Specific Advanced Funding:

1. The Policyholder’s premium payments must be current through the month in which the claim is submitted.
2. The Plan must have Paid and fully funded all Plan Benefits up to the Specific Deductible Amount, prior to the expiration of the Specific Stop Loss Policy.
3. All claims submitted for Specific Advance Funding must be fully processed according to the Plan Document and the Stop Loss Policy, and must be ready for payment.
4. The Plan must include all required documentation in requesting reimbursements as described on this document and the Stop Loss Notification/Initial Claim or the Stop Loss Subsequent Claim Form.
5. Upon receipt of the Specific Advanced Funding reimbursement, the Plan must release all Plan Benefit check(s) within five (5) working days and submit documentation to The Union Labor Life Insurance Company as confirmation that payment(s) have been released to the corresponding provider(s).
Special Note:

The Stop Loss Policy is written on reimbursement basis only. This means the Plan is responsible for paying all eligible claim expenses prior to filing a reimbursement request. Specific Advance Funding reimbursement assists clients with payment of large medical charges only and does not change any of the terms or provisions of the Policy.

Therefore, if requesting Specific Advance Funding, it is critical that all guidelines outlined above are carefully followed. If these guidelines are not followed, your Specific Claim Reimbursement submission will be handled strictly on a reimbursement basis only.

Furthermore if, for any reason, the Plan Sponsor does not use the advance funding or any portion of it to Pay the Eligible Expense within five (5) working days of receipt of the advance funding, the Plan Sponsor will return the unused portion of the advanced funding to the Company within five (5) working days.

The amount owed to the Plan Sponsor as the Specific Stop Loss Reimbursement will be reduced by any amounts provided as advance funding under this Policy for the same Benefit Period. At the end of the Benefit Period, any advance funding amounts that exceed the Specific Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.
IV. AGGREGATE CLAIM REIMBURSEMENT REQUESTS

An Aggregate Claim occurs when Plan Benefits Paid on behalf of all Covered Persons exceed the Minimum Annual Aggregate Deductible (Minimum Aggregate Attachment Point). Aggregate claims are typically filed after the Aggregate Benefit Period has expired and the total Eligible Claim Expenses can be determined.

A. Reporting Requirements

The Union Labor Life Insurance Company requires Monthly Aggregate Reporting by the fifteenth (15th) day following the end of each month of the Policy Period. Monthly Aggregate Reporting assists The Union Labor Life Insurance Company in documenting and monitoring potential Aggregate claims.

The following should be included with your Monthly Aggregate Reporting:

- The number of Covered Units by coverage type for each of the Plan, for each of the month of the Policy Period; and
- Monthly and Year-to-Date Total Claims Paid as well as deductions for ineligible claim expenses, such as Specific Claims, voids and/or refund and extra contractual benefit payment for each of the Plan, for each of the month of the Policy Period.

B. Aggregate Accommodation

The Aggregate Accommodation is intended to aid the cash flow of the Plan to reimburse certain benefits otherwise reimbursable at the end of the Policy Period. Aggregate Accommodation is not intended to be a loan nor a cash advance. The Plan therefore must pay all claims prior to receiving an Aggregate Accommodation reimbursement.

If the Policy allows The Union Labor Life Insurance Company may make an Aggregate Accommodation upon the Plan Sponsor’s proper filing of an Aggregate Accommodation reimbursement request if in any month during the Policy Period, the Total Claims Paid, less ineligible claims, exceeds the sum of:

1. the greater of (a) the accumulated Annual Aggregate Attachment Point or (b) the pro rata of the portion of the Minimum Annual Aggregate Attachment Point; and
2. any previous advances; and
3. $1,000.

Filing Guidelines

The following documentations are required when filing an Aggregate Accommodation reimbursement request:

a. Completed Monthly Accommodation Claim Form (please refer to the Forms section of this Guide);

b. Monthly Loss Summary Reports as described under the Monthly Aggregate Reporting requirement on Section IV, A;
c. Paid Claims Analysis Report showing claimant’s name, date(s) of service, type of service, amount charged, and amount, date and Payee for each Payment made.

For the purpose of Aggregate Accommodation Reimbursement, the following conditions apply:

1. All claims must be Paid by the Plan Sponsor prior to applying for an Aggregate Accommodation Reimbursement.
2. Aggregate Accommodation Reimbursement must be equal or greater than $1,000.
3. Aggregate Accommodation Reimbursement is not available in the final month of the Aggregate Benefit Period.
4. The amount owed to the Plan Sponsor as the Aggregate Stop Loss Reimbursement will be reduced by any amounts paid under the Policy for the same Plan Period as Aggregate Accommodations that were not repaid as overpayments and were not offset against the Specific Stop Loss Reimbursement. At the end of the Plan Period, any Aggregate Accommodations or any portion thereof that exceed the Aggregate Stop Loss Reimbursement must be repaid within thirty (30) days of written notice from Us.

C. Year End Aggregate Claims

Year End Aggregate Claims must be filed with The Union Labor Life Insurance Company within 90 days after the end of the time specified for payment of claims under the Stop Loss Policy.

Filing Guidelines
The following documentations are required when filing a Year End Aggregate Claim:

a. Completed Year End Aggregate Claim Form (please refer to the Forms section of this Guide);

b. Paid Claims Analysis Report indicating claimant’s name, Incurred date, charged amount, Paid amount and Paid data;

c. Eligibility listing which identifies birth date, effective date, termination date and coverage type;

d. Proof of funding including monthly bank statements or other documentation of claims account funding;

e. List of Voids, Refunds, Credits, Reversals and extra-contractual claims;

f. Specific report showing which claimants have exceeded the Specific Deductible or loss limit;

g. Benefit/Service Code report;

h. Monthly Loss Summary Reports as described under the Monthly Aggregate Reporting requirement on Section IV. A;
i. Listing of payments made outside the Aggregate contract (i.e. Dental, Weekly Income, Vision, PPO Fees – Capitated, etc);

j. Outstanding overpayment and subrogation log;

k. If prescription drug charges are included, itemized monthly invoices and verification of Payment, if not included on the monthly check registers;

l. COBRA documentation for COBRA participants; and

m. Other documentation We may request.

We may also request this information the month following the expiration date of the Policy to review for retroactive adjustments.

D. Right to Audit

Depending on several factors, The Union Labor Life Insurance Company may require an “on-site” verification of a year-end Aggregate claim. Upon receipt of the complete submission, we will perform a preliminary review of the request. The Union Labor Life Insurance Company will then determine if we will do an “in-house” desk audit or an “on-site” audit, performed in the office of the TPA.

In the event of an “on-site” audit, an auditor will be assigned to the claim. The auditor will contact the TPA for any required additional information and to schedule an audit date. If the audit is done “in-house,” the complete, fully documented Aggregate Stop Loss claim will be reviewed, the audit process completed, and claim determination made within 30 to 60 calendar days.
V. GENERAL PROVISIONS

A. Eligibility

The Union Labor Life Insurance Company strictly adheres to the Eligibility requirements as defined under the Plan Document or Summary Plan Description (SPD). It is extremely important that all parties understand the Plan benefits and that The Union Labor Life Insurance Company be provided with information that clearly and precisely indicates how a person has been determined to be eligible under the Plan. It is for this reason that our Stop Loss Notification and Initial Claim Form and our Stop Loss Subsequent Claim Form request detailed information on how a claimant has been and continues to be eligible under the Plan. In order for The Union Labor Life Insurance Company to perform a complete and thorough review, these questions must be answered and the required documents listed on the forms be submitted in their entirety. Failure to do so may delay the review process.

For your convenience, we have included a Work Status Questionnaire under the Form section of this Guide.

B. Third Party Liability and Subrogation Procedures

Third Party Liability/Subrogation involves situations where another (third) party is responsible for payment of health care expenses he/she incurs because of someone else’s act or omission. It provides the Plan with an opportunity to shift the cost of the claimant’s medical care onto another responsible party. The other party may be an individual, insurance company or some other public or private entity. The Subrogation provision allows for the right of recovery for payments made under the Plan from the other party.

In order for us to review and issue reimbursement on cases involving Third Party Liability/Subrogation, we must first have the following documentation:

1. The Union Labor Life Insurance Company Liability Questionnaire Form (or similar TPA form) completed by either the TPA or the Policyholder. Please include any appropriate attachments; and
2. A Subrogation and Right to Recover Reimbursement Agreement signed by the Policyholder.

C. Overpayments & Refunds

All Specific and Aggregate claim refunds should be forwarded to The Union Labor Life Insurance Company immediately. Although refunds may not have been identified by the Policyholder immediately, once they are identified to be due to an overpayment of a Specific or Aggregate claim, such refunds rightfully belong to the Company and should be sent to The Union Labor Life Insurance Company at once.
D. Claims to Appeal

Any claim that has been denied can be appealed within 90 days after the determination has been made by submitting supporting documentation or by providing additional evidence in writing to:

The Union Labor Life Insurance Company  
8403 Colesville Road, 13th Floor  
Silver Spring, MD 20910  
Attention: Stop Loss Claims Unit (APPEALS)

Or

Via fax at: (202) 682.6920

Or

Via E-Mail at: StopLossClaims@ullico.com

The Union Labor Life Insurance Company may enlist the services of qualified outside physician consultants to support denials based on medical necessity or experimental and investigational provisions in the Stop Loss Policy.

The Union Labor Life Insurance Company will adhere to the following appeal levels.

- **Level I** - First appeal - performed by the VP of Operations and the AVP of the Compliance Department, in consult with the chief Compliance Officer;

- **Level II** - Second and final appeal - performed by the President of The Union Labor Life and Ullico’s Chief Operating Officer, in consult with Ullico’s General Counsel.

All decisions made at Level II are final.

In the event that the Plan requests for an external review by an Independent Review Organization (IRO), due to an Adverse Benefit Determination as required by law, and such review resulted to a reversal or modification of the Adverse Benefit Determination, the Paid date of the claims will be the date that such Adverse Benefit Determination was made. Please refer to the Stop Loss Policy for additional information and conditions affecting Adverse Benefit Determination.

E. Contract Terms

Stop Loss claims are reimbursed depending on when the eligible charges are Incurred and Paid. The Incurred and Paid dates represent the essence of the Stop Loss coverage. It is critical that the Policyholder understands what “Incurred” and “Paid” means. Please refer to the Definition section of this guide.
The Union Labor Life Insurance Company offers the following Specific and Aggregate Contract Terms based on the Policyholder’s Incurred and Paid date parameters:

<table>
<thead>
<tr>
<th>Date of Incurred and Paid</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/12</td>
<td>Incurred in the Policy Period or within three (3) months prior to the Policy Period and Paid in the Policy Period</td>
</tr>
<tr>
<td>15/12</td>
<td>Incurred in the Policy Period or within three (3) months thereafter</td>
</tr>
<tr>
<td>12/18</td>
<td>Incurred in the Policy Period or within twelve (12) months thereafter</td>
</tr>
</tbody>
</table>

**F. Split Funding or Aggregated Specific Deductible Option**

The Union Labor Life Insurance Company offers pricing alternatives designed to help Policyholders manage Premium increases. This funding arrangement provides the Policyholder an opportunity to reduce Specific Stop Loss Premium cost by sharing in the claims risk of the Aggregated Specific in return for reduced premium.

If there is an individual(s) that exceeds the Specific Attachment Point, the Policyholder forgoes reimbursement until a predetermined risk corridor, the Aggregated Specific Deductible, has been satisfied. It is important that the Policyholder submit all specific claims during the Policy Period even if they are still within the corridor for record keeping purposes. The minimum premium amount plus the corridor will typically match the traditional premium charged.

This premium methodology can be a valuable tool for Policyholders to reduce fixed premium costs, especially for those with favorable loss experience and solid cash flow. Based on the level of risk assumed by the Policyholder, this product provides the opportunity to keep their fixed costs flat during subsequent renewals.

**G. Summary Plan Description (SPD) and its Amendments**

The Union Labor Life Insurance Company relies on the Summary Plan Description (SPD) in determining Eligible Expense as it is the basis on which claims are paid. It is significantly important that The Union Labor Life Insurance Company receives the latest version of the SPD.
Summary Plan Description (SPD) for approval in accordance with the provisions of the Stop Loss Policy.

Any changes, amendments or modifications to the SPD should be submitted to The Union Labor Life Insurance Company for prior approval and will be in effect on the first day of the month following the Company’s approval of the proposed amendment.

In the absence of the Company’s prior written consent of the amendment, benefits will be payable under this Policy as though the Plan Document had not been amended.

VI. COST CONTAINMENT INITIATIVES

Advances in medical technology have increased healthcare costs and have created the opportunity for providers to shift higher charges for such services to health insurance payers and self-funded Plan Sponsors. The Union Labor Life Insurance Company adheres to providing your members with high quality of care while applying a series of initiatives that supports cost effective solutions through our Cost Containment Programs, including:

- Large Case Management (LCM) services;
- Hospital Bill Review and line-item audits;
- Bill re-pricing & Prompt Payment Discount Negotiations;
- Specialty Vendor Access for:
  - Outcome-based Centers of Excellence Transplant Network
  - Evidence-based Cancer Program
  - Dialysis treatments
  - Prenatal/neonatal services; and
  - Pharmacies: specialty drugs, injections and infusions

Through relationships with leading cost containment vendors, The Union Labor Life Insurance Company has developed this program to control medical claim costs which will not only protect the assets of the Plan Sponsor, but also allow our Company to offer more competitive, preferred pricing on Stop Loss renewals. In order for the program to maximize savings opportunities, a collaborative effort is necessary between the Plan, its claims administrator (TPA) and The Union Labor Life Insurance Company.

The TPA/Administrator should forward claims which meet the claims submission criteria as listed below to The Union Labor Life Insurance Company for review and cost containment opportunities. The submission criteria includes both in and out of network claims as well as specialized potential high dollar situations such as transplant cases, dialyses and cancer treatments.

While the utilization of our cost containment services is voluntary, we strongly encourage submission of your claims for cost containment review prior to claims payment to ensure the greatest cost savings.
Medical Records may not necessarily be required as part of your claim submissions. However, The Union Labor Life Insurance Company reserves the right to request this documentation, as it is often invaluable in providing key information in our investigational phase.

Should the TPA/Administrator opt not to utilize the cost containment services, there will be no penalty or other type of reduction as a result of such decision. However, The Union Labor Life Insurance Company reserves the right to retain such services and by doing so, may produce a lower than expected Stop Loss reimbursement.

All reimbursements remain subject to the provisions of the Stop Loss Policy.

A. **Large Case Management (LCM)**

Large Case Management (LCM) as defined by the Case Management Society of America (CMSA) is a “collaborative process of assessing, planning, facilitation and advocacy for options and services to meet an individual’s health need through communication and available resources to promote quality cost-effective outcomes.”

The Union Labor Life Insurance Company promotes the use of Large Case Management (LCM) services and will work with the Policyholder’s case manager(s) or refer the case to LCM vendors, which have been chosen for their quality services and clinical specialties, for specialized management once a case has been identified.

Since Large Case Management is directly associated with the management of an on-going catastrophic claim, LCM fees associated with the management of an on-going catastrophic claim, that are considered operational/administrative functions are NOT reimbursable under the Stop Loss Contract. This includes the cost for sending e-mails, faxes, etc; internal claim services, including eligibility determination; clerical fees; or capitated fees that are charged to the Plan on a per member, per month basis.

Proper management results in savings and the cost of such management is reimbursable under the Stop Loss Policy provided that:

a. the claim payments in addition to the LCM fees exceed the Specific Deductible, and LCM is warranted;
b. The Union Labor Life Insurance Company requested for LCM implementation; and
c. The fees are incurred and paid in accordance to the Policy’s Terms.

If the Plan or its TPA opens a case to LCM and the Policyholder’s Specific Deductible is eventually exceeded, those fees will be reimbursed above the Specific Deductible as part of the overall claims needed to be reimbursed, once such Claim is submitted to The Union Labor Life Insurance Company for reimbursement. Copies of the LCM reports must be submitted with the Claim.
B. Hospital Bill Review and Line-item Audits

Although we found that significant savings are realized through preferred providers organizations (PPO) network discounts, we have also found some preferred providers are taking advantage of loop holes in their PPO contracts, especially when the contract included provisions which exempt them from standard bill reviews for inappropriate coding combinations, also known as “unbundling” and “upcoding”, or reasonable and customary (R&C) allowances. Moreover, there has recently been a resurgence of hospital audit within the cost containment arena as a result of hospital over billing, particularly in the area of pharmacy charges.

The Union Labor Life Insurance Company encourages the Plans or their TPAs to pre-screen all hospital bills, whether in or out-of-network, or refer them to us or your preferred vendors for further review and/or audit. We recommend that hospital bill review audits be conducted on claims where the hospital charge is in excess of $100,000. The Union Labor Life Insurance Company can assist in the review of hospital audit results.

If an audit is requested, a provider agreement outlining the adjusted charges must be obtained. The agreement should also establish a definitive timeframe for payment and include an agreement not to balance bill the patient.

Once the Specific Deductible is exceeded, fees associated with the audit will be considered an eligible claim for the purpose of Stop Loss. Reimbursement of audit fees is limited to 25% of savings. Copies of the audit result and the agreement must be submitted with the Claim.

C. Bill Re-Pricing & Prompt Payment Discount Negotiations

Oftentimes, when charges are believed to be excessive, the result of a hospital audit can be utilized as benchmark for provider negotiation. We have found that providers are more inclined to accept bill re-pricing and prompt payment discount negotiations in lieu of hospital audit agreements. Negotiating prompt payment discounts has demonstrated plan savings equal to or greater that those found through the standard PPO contract as providers may be willing to accept the negotiated amounts in order to ensure timely recovery of their receivables.

The Union Labor Life Insurance Company recommends the Plan or its TPA to pursue Bill Re-Pricing & Prompt Payment Discount Negotiations as actively as possible, on their own or through a preferred vendor.

The fee for this service is generally charged at a percentage of savings averaging at 30%. Vendors do not normally charge if they are unsuccessful in the negotiations. The Union Labor Life Insurance Company maintains valuable relationships with such vendors and will be happy to assist you.

If a Bill Re-Pricing & Prompt Payment Discount Negotiations is requested, a signed agreement with the provider outlining the adjusted charges must be obtained. The agreement should also establish a definitive timeframe for payment and include an agreement not to balance bill the patient.
Once the Specific Deductible is exceeded, fees associated with the Bill Re-Pricing & Prompt Payment Discount Negotiations will be reimbursed above the Specific Deductible as part of the Specific claim, once such Claim is submitted to The Union Labor Life Insurance Company for reimbursement. Reimbursement of audit fees is limited to 30% of savings. Copies of the agreement must be submitted with the Claim.

D. Specialty Vendor Access

**Outcome-based Centers of Excellence Transplant Network.** The Union Labor Life Insurance Company maintains special relationship with innovators in outcome-based care-improvement programs. Focusing on high cost, low frequency procedures, intensive credentialing, procedure outcome collection methods and evidence-based treatment protocols, thus achieving lower care costs through good medical outcomes. Through the Centers of Excellence Transplant Network patients can access nearly 80 of the nation’s most noted transplant centers at great contract rates to health plans, candidate education tools and case manager support programs.

The Transplant Program will typically offer case rate pricing for the entire transplant continuum of care.

**Evidence-based Cancer Program.** Recognizing that cancer treatment is a large and growing expense for health plans, through our preferred vendor, the Plan can access this program which offers the total cancer care solution, featuring experienced oncology care coordinators, specialized cancer care management and a network of leading cancer centers across the country.

**Dialysis treatments.** Managing dialysis claims remains a challenge since dialysis providers rarely participate in PPO networks, yet billed charges for dialysis treatments can total up to $70,000 per month. Dialysis claims can be devastating to a self-funded Plan without proper cost containment. Roughly 80% of all renal dialysis costs are paid by Medicare, 10% by Medicaid and Veterans Programs and 10% by the commercial market. With Medicare, Medicaid and Veterans Programs price-controlled by the government and fully insured markets using their buying power to negotiate significant discounts, it’s easy to understand why costs have risen so dramatically for the self-funded population.

Since individuals receiving dialysis for treatment of end stage renal disease (ESRD) are eligible for both Medicare Parts A & B, it is imperative that Plans are aware of the basics of this federally funded programs and its rules on Coordination of Benefits.

The Union Labor Life Insurance Company will assist and act as a resource in the management of dialysis claims. We can refer dialysis claims to our preferred vendors who will either negotiate directly with the providers to obtain deeper discounts, or apply R&C allowances based on thorough review of the actual billed charges.
**Prenatal/Neonatal services.** Premature and severely ill neonates present a challenge because of the complex care needs and their associated cost. Treatment of high-risk newborns is a lengthy process that requires large amounts of personal and monetary resources.

The Union Labor Life Insurance Company will assist and act as a resource in the management of Prenatal/Neonatal claims. We can refer such claims to our preferred vendors who will either negotiate directly with the providers to obtain deeper discounts, or apply R&C allowances based on thorough review of the actual billed charges.

**Pharmacies: specialty drugs, injections and infusions.** The rising cost of pharmaceuticals is a major concern in healthcare today. This is especially critical for people with chronic conditions who are on multiple high cost medications. Plans today rely heavily on their Pharmacy Benefit Manager (PBM) to control their prescription drug costs, but most expensive drug therapies, those typically biotech in nature, cannot be delivered through traditional PBM channels. Because there is limited competition and typically no cost controls in place, specialty pharmaceuticals are often a safe haven for cost shifting within the healthcare provider chain.

Through our relationships with several Specialty Pharmacy Benefit Management companies who provide specialized patient management services, The Union Labor Life Insurance Company is able to provide you with access to lower cost of such specialty drugs, injections and infusions.
VII. DEFINITION OF TERMS

The following terms are commonly used by both the TPA and Stop Loss claim staff. This list does not represent all Policy definitions. Please refer to the Policy if there are any questions regarding coverage or terms.

**Advanced Funding** - Also commonly referred to a *Simultaneous Funding*, the Advanced Funding option permits a self-funded Plan to apply for Specific Stop Loss reimbursement before the Plan’s claim is fully funded.

**Adverse Benefit Determination** means a determination made by the Plan, its Administrator, or its designee utilization review organization that a health care service or supply has been reviewed and was determined as not meeting the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or supply, or payment for the service or supply is therefore denied, reduced or terminated.

**Aggregated Specific Deductible** - An Aggregated Specific Deductible is an additional corridor deductible amount that must be satisfied by one or more plan participants after they have exceeded their individual specific deductible. Once this additional corridor deductible has been satisfied, then the Plan may submit a claim for reimbursement under the Stop Loss Policy.

**Aggregate Stop Loss** - Aggregate Stop Loss is protection for the Plan against catastrophic losses when the total claims for all covered members and dependents exceed the Aggregate Attachment Level for the contract year.

**Benefit Period** – The period of time during which the Eligible Expenses must be Incurred by a Covered Person and Paid by the Policyholder to be eligible for reimbursement under the Policy.

**Contract Basis** - The “Contract Basis” (or “Claims Basis”) defines which claims are eligible for reimbursement under the Stop Loss contract in a specific year. The Stop Loss contract basis falls into two general categories, depending on whether the claims above the Stop Loss attachment level are covered on an “incurred” or “paid” basis. Variations of each approach exist.

**Covered Person** – The individual covered under the Plan

**Covered Unit** – An individual, an individual with dependents or such other defined unit as agreed upon and shown on the Application

**Eligible Expenses** – The eligible charges payable under the Plan and for which the Plan is liable to pay. It does not include expenses specifically excluded or limited by the Policy, Application for Policy, Schedule of Insurance or any Endorsements.

**Explanation of Benefit (EOB)** - A detailed summary of medical expenses submitted, allowed, disallowed and paid by the Claims Administrator or the TPA on behalf of the Plan.

**Explanation of Reimbursement (EOR)** - A detailed summary of the medical expenses submitted, allowed, disallowed and paid by the Stop Loss Carrier to the Plan.

**Large Claim** - This means Paid or pending claims reaching or with the potential to reach 50% of the Specific Deductible or a Potentially Catastrophic Loss.
Minimum Annual Aggregate Deductible – Also known as the Minimum Attachment Point, the Minimum Annual Aggregate Deductible is the amount as shown in the Policy schedule or, if the schedule does not show such amount or shows such amount as zero, is the amount equal to the product of the number of months into the Policy Year times the Monthly Attachment Limit for the first Policy Month of the applicable Policy Year. It is established to protect The Union Labor Life Insurance Company against unfavorable Aggregate experience that may be generated by a shrinking or downsizing self-funded plan.

Paid (Payment) – This means that a claim has been adjudicated by the TPA and the funds are actually disbursed by the Plan prior to the end of the Benefit Period. Payment of a claim is the unconditional direct payment of a claim to the Covered Person or their health care provider(s). Payment will be deemed made on the date that both:

1. The payer directly tenders payment by mailing (or by other form of delivery) a draft or check; and
2. The account upon which the payment is drawn contains and continues to contain, sufficient funds to permit the check or draft to be honored by the institution upon which it is drawn.

Plan Benefits - This means the health benefits covered by the Plan during the Policy Period which are:

1. Incurred on or after the Effective Date of the Policy; and
2. Incurred while the Policy is in force; and
3. Incurred and Paid during the Policy Period.

Plan Benefits will also include those health benefits covered by the Plan during the Policy Period which are Paid during any Run-Out period or Incurred during any Run-In Period applicable to this Policy. Plan Benefits do not include:

1. deductibles of the Plan;
2. co-insurance or co-payment amounts of the Plan;
3. any expenses that are not covered by the Plan or this Policy;
4. any amount recoverable from any other source; or
5. any amount Paid under a previous Policy or arrangement or excess loss coverage, whether issued by SLG Benefits, on behalf of the insurance company or another entity.

Policy Period - This means the time period beginning on the Effective Date and ending on the Expiration Date.

Run-in Limit - This means the maximum benefit amount Paid by the Policyholder under the Plan for Eligible Expenses Incurred by a Covered Person during the Run-in Period will be considered when determining benefit payments under this Policy.

Run-in Period - This means the period of time shown in the Schedule of Insurance immediately prior to the first day of a Policy Period during which Eligible Expenses Incurred by a Covered Person, which are Paid by the Policyholder during the Policy Period, will be considered when determining benefit payments under this Policy.

Run-out-Period - This means the period of time shown in the Schedule of Insurance immediately following the Policy Expiration Date during which Plan Benefits Paid by the Policyholder for Eligible Expenses Incurred by a Covered Person during the Policy Period will be considered when determining benefit payments under this Policy.
Specific Deductible: Specific Deductible means the amount which is wholly retained by the Plan Sponsor as shown in the Schedule of Stop Loss. The Specific Deductible applies separately to each Plan Participant for each Plan Period. The Specific Deductible for each subsequent Plan Period will be determined by The Union Labor Life Insurance Company.

Specific Payable Percentage - The Stop Loss Policy reimburses eligible claims at a pre-determined percentage. Depending on the product purchased, the Stop Loss Policy may reimburse all claims at a single percentage (normally 100%) or may provide reimbursement at a percentage up to a certain dollar level, and another percentage for claims exceeding the established dollar level. The applicable percentages are stated in the Policy.

Summary Plan Description (SPD) – Sometime referred to as the Plan Document means the written form of the Benefit Plan, which must be filed with and approved by The Union Labor Life Insurance Company. The SPD is the basis on which claims are paid under this Policy. Without such document on file, claims will not be paid. The SPD includes any amendments that are approved in accordance with the provisions of this Policy.

(Usual or) Reasonable and Customary Charges - The amount calculated by Us with reference to the charges for the same service by such providers in the same or similar geographic area in which the care is provided. To determine this amount, The Union Labor Life Insurance Company uses an industry-wide data system that collects data on providers’ charges by zip code and procedure code. The industry-wide data system arrays these charges and calculates percentiles. The prevailing fee is the 90th percentile of these charges. This means that 90% of the charges are at or below the prevailing fee for the same service in the same or similar geographic area.

The prevailing fee is developed from a statistically valid sample which:

1. equitably recognizes geographic variations;
2. is produced every six months; and
3. is collected on the basis of procedure codes developed and maintained by recognized authorities.
VIII. STOP LOSS UNIT CONTACT INFORMATION

The Union Labor Life Insurance Company
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Attention: Stop Loss Claims Unit

Toll Free Number: 1-800-328-5837
Fax Number: 1-202-682-6920
Email Address: StopLossClaims@ullico.com
Web Address: http://www.ullico.com/

Hours of Operation: Monday – Friday 8:00 a.m. to 4:30 p.m. (Eastern Time)

For information regarding our cost-containment vendors and transplants network contact:

Nurse Case Manager: 1-800-328-5837 Ext. 8987
AVP of Claims: 1-202-682-4696

For other inquires pertaining to Premium Billing and Policy Issues:

Premium Billing: 1-888-222-8573
E-mail: premiumbilling@ullico.com

Policy Issues: 1-202-682-6905
E-mail: kfullen@ullico.com
IX. PRIVACY NOTICE

This Privacy Notice is sent to our customers who have received or continue to receive products and services provided by the following companies within The Union Labor Life Insurance Company Family of Companies.

- The Union Labor Life Insurance Company
- ULLICO Life Insurance Company
- Ulico Casualty Company
- UNIONCARE, Inc.
- Ulico Standard of America Casualty Company
- MRCo, Inc.
- ULLICO Mortgage Corporation

Your Privacy is Important to Us

We value you as a customer and we want you to know that protecting your privacy is very important to us. We also want you to know the types of information we collect and how we use it in the course of our business. We are also required by law to inform you of our policies and procedures for collecting, protecting, using and sharing your nonpublic personal information. You will receive a copy of our privacy notice when you first become one of our customers, whenever we change our notice, and annually each year that you remain one of our customers. If you have any questions concerning this notice, or our privacy practices, please contact us using the information listed at the end of this notice.

Information We Collect

We collect and use nonpublic personal information to notify you of products and services that we offer, to provide customer service to you, and in the normal course of our business operations. “Nonpublic personal information” includes all information we obtain about you in connection with providing a financial service or product to you, and it may come from the following sources:

- Information provided on applications, or other forms as part of the application process. This information is received either directly from you or through one of our representatives.
- Information provided during our business transactions with you, such as your claims history or payment history.
- Information provided by third parties, including medical records, credit reports and eligibility records.

Information We Share With Others

We share nonpublic personal information about our customers and our former customers within our Family of Companies and to selected third parties as permitted or required by law in conjunction with our normal business operations. This may include processing a claim, administering or enforcing a transaction, servicing your account, billing, auditing, reinsuring, or providing
information to industry regulators, enforcement agencies or required by a court of law in connection with a legal proceeding. We may also disclose information to third parties that assist us in marketing our products and services to you.

We do not sell or rent nonpublic personal information to third parties.

We Protect Your Information

We maintain physical, electronic and procedural security standards to ensure that access to your nonpublic personal information is limited to our employees, agents and to third parties who work with us and have a legitimate need for the information in order to provide products and services to you. Third parties are also required to know and to comply with our privacy policies and practices.

Questions

Please contact us at the following address or phone number, if you would like more information concerning our privacy policies.

Contact Office Mailing Address:
The Union Labor Life Insurance Company
1625 Eye Street, N.W.
Washington, D.C. 20006
Attn: Privacy Officer

Telephone: 1-800-431-5425
Website: www.ullico.com
X. FORMS

A. Specific Stop Loss Claim Form (Initial Filing/Notification Form)
B. Subsequent Specific Stop Loss Claim Form
C. Monthly Aggregate Accommodation Reimbursement Form
D. Year End Aggregate Claim Form
E. Work Status Questionnaire
F. Third Party Liability Questionnaire
G. Right of Recovery/Subrogation Agreement
H. Subrogation Agreement
SPECIFIC STOP LOSS CLAIM
INITIAL FILING OR NOTIFICATION FORM

Please submit this form to:
The Union Labor Life Insurance Company
Stop Loss Claims Unit
8403 Colesville Rd., 13th Floor • Silver Spring, MD 20910
Toll free: 600-329-9607 • Fax: 1-202-682-6500
StopLossClaims@Ullico.com

☐ Initial Claim    ☐ Claim Notification (50% Notice or trigger diagnosis)

POLICYHOLDER INFORMATION:
Plan Sponsor (Group) Name: _________________________    Policy #: _________________________
Policy Period: ________________    Contract Type: _________________________    Specific Deductible: _________________________

MEMBER INFORMATION:
Member Name: _________________________    Soc Sec #: _________________________
Date of Birth: _____________    Date of Hire: _____________    Original Effective Date: _____________    Plan #: _________________________

MEMBER’S WORK STATUS:
☐ Actively working    ☐ Retired - Retirement Date: _________________________
☐ Disabled and unable to work from: _________________________ to _________________________
☐ Not actively working    Date last worked: _________________________

Indicate how coverage is being continued (mark all that apply):
☐ Sick Leave: _____________ to _________________________
☐ Vacation: _____________ to _________________________
☐ Leave of Absence: _____________ to _________________________
☐ FMLA: _____________ to _________________________
☐ Hour Bank? ☐ Yes (please provide copy of report) ☐ No
☐ Self pay: _________________________ to _________________________
☐ Coverage Terminated? ☐ Yes ☐ No    Date: _________________________
☐ COBRA applicable? ☐ Yes ☐ No    COBRA Effective Date: _________________________
COBRA Premium Paid Through: _________________________    COBRA Termination Date: _________________________

CLAIMANT INFORMATION:
Claimant Name: _________________________    Date of Birth: _________________________
Relationship to Member: ☐ Spouse ☐ Child ☐ Other ☐ If child, Full Time Student: ☐ Yes ☐ No
Original Effective Date: _________________________    Termination Date: _________________________

Is COBRA applicable? ☐ Yes ☐ No    COBRA Effective Date: _________________________
COBRA Premium Paid Through Date: _________________________    COBRA Termination Date: _________________________

Is Claimant covered by any other insurance plan? ☐ Yes ☐ No
If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare): _________________________
Carrier: _________________________    Effective Date: _________________________    Termination Date: _________________________

Is Pre-existing applicable? ☐ Yes ☐ No    Pre-existing Condition: _________________________
Please provide pre-existing/HIPAA documentation
SPECIFIC STOP LOSS CLAIM
INITIAL FILING OR NOTIFICATION FORM

CLAIM INFORMATION:

Diagnosis: ____________________________ Date of Onset: ________________ Prognosis: ___________________

Claimant injured? ☐ Yes ☐ No Date of Injury: ________________ Place Injury Occurred: ___________________

How did injury occur? ____________________________________________________________________________

Subrogation applicable? ☐ Yes ☐ No If “Yes”, please provide details: _______________________________________

PPO? ☐ Yes ☐ No Name of PPO: __________________________

Case Management? ☐ Yes ☐ No Vendor Name & Phone: ____________________________

Claims Paid to Date: $ ________________ Claims Pending: $ ________________

SPECIFIC STOP LOSS CLAIM FORM

Total Eligible Benefits this Submission: $ ________________

Less Specific Deductible: $ ________________

Less Aggregating Specific Deductible (if Applicable $ ________________

Balance: $ ________________

Percentage to be Reimbursed: % ________________

Reimbursement Requested: $ ________________

Simultaneous (Advanced) Funding Requested: ☐ Yes ☐ No

Simultaneous Amount being Requested: $ ________________

YOUR REQUEST SHOULD INCLUDE COPIES OF THE FOLLOWING INFORMATION: (IF APPLICABLE)

Enrollment Form (initial/current) Hospital Audits/Reviews
Member Claim Form Hospital Records
Copy of Hour Bank/Dollar Bank Large Case Management Reports
Proof of Premium Payments Cumulative paid claims report
COBRA Election form & Proof of Payment Medicare Investigative materials to support claim:
Election Form/Medicare Card EOB/Claim • COB
check/Registers • Full time student status
Deductible/Coinsurance Proof of satisfaction Divorce or • Pre-existing/HIPAA Documents
Separation Decrees or Court Orders • Physician’s Statements
Complete Paid Claims Detail/History Report • Subrogation information
Itemized Bills/Electronic Claim Data • Work Comp information
R&C Calculations • Accident Details (police report, etc.)
Pre-certification Forms

TPA/Claims Administrator Name: ____________________________________________________________

Address: ________________________________________________________________________________

Phone: __________________ Fax: __________________ E-Mail __________________

Page 2 of 5
SPECIFIC STOP LOSS CLAIM
INITIAL FILING OR NOTIFICATION FORM

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ATTACHED FRAUD NOTICE, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Authorized Signature: ________________________________ Date: ________________

SUBMIT TO:
THE UNION LABOR LIFE INSURANCE COMPANY
8403 Colesville Road, Suite 1300 Silver Spring, MD 20910
Toll Free Phone: 1-800-328-5837 • Fax: 1-240-682-6929 • E-mail: stoplossclaims@ullico.com

SPECIFIC STOP LOSS CLAIM FORM
FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Arizona: 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 and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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.

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

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.
Georgia, Kansas, Oregon, Vermont: Any person who with intent to defraud or knowing that he/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.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Maine, Tennessee, Washington: 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.

Maryland: 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.

Nebraska: 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 materially false or deceptive statement is guilty of insurance fraud.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.

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.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
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 include imprisonment, fines and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.
Subsequent Specific
Claim #_____  Stop Loss Claim Form

ACCOUNT INFORMATION:
Plan Sponsor (Group) Name: ________________________________ Policy #: ________________________________
Policy Period: ________________________________ Contract Type: ________________________________ Specific Deductible: ________________________________
Member Name: ________________________________ Soc Sec #: ________________________________
Claimant Name: ________________________________ Date of Birth: ________________________________
Diagnosis: ________________________________ Prognosis: ________________________________

PLEASE UPDATE THE INFORMATION LISTED BELOW TO REFLECT ANY CHANGES:

Member Work Status:
☐ Actively working  ☐ Retired - Retirement Date: ________________________________
☐ Disabled and unable to work from: ________________________________ to ________________________________
☐ Not actively working  Date last worked: ________________________________
Indicate how coverage is being continued (mark all that apply):
☐ Sick Leave: ________________________________ to ________________________________  ☐ Vacation: ________________________________ to ________________________________
☐ Leave of Absence: ________________________________ to ________________________________  ☐ FMLA: ________________________________ to ________________________________
☐ Hour Bank? ☐ Yes (please provide copy of report) ☐ No
☐ Self pay: ________________________________ to ________________________________ (please provide proof of premium payments)
☐ Coverage Terminated? ☐ Yes ☐ No  Date: ________________________________
☐ COBRA applicable? ☐ Yes ☐ No  COBRA Effective Date: ________________________________
COBRA Premium Paid Through: ________________________________  COBRA Termination Date: ________________________________

Other Insurance Information:
Is Claimant covered by any other insurance plan? ☐ Yes ☐ No
☐ If yes, type of coverage (Auto, Work Comp, Group Plan, Medicare): ________________________________
Carrier: ________________________________ Effective Date: ________________________________ Termination Date: ________________________________

CLAIM INFORMATION:
Claimant injured? ☐ Yes ☐ No  Date of Injury: ________________________________ Place Injury Occurred: ________________________________
How did injury occur? ________________________________
Subrogation applicable? ☐ Yes ☐ No ☐ If "Yes", please provide details: ________________________________
PPO? ☐ Yes ☐ No  Name of PPO: ________________________________
Case Management? ☐ Yes ☐ No  Vendor Name & Phone: ________________________________
Claims Paid to Date: $ ________________________________  Claims Pending: $ ________________________________
Subsequent Specific
Claim # _____
Stop Loss Claim Form

Total Eligible Benefits this Submission: $ __________
Less Specific Deductible: $ __________
Less Aggregating Specific Deductible (if Applicable) $ __________
Balance: $ __________
Percentage to be Reimbursed: %
Reimbursement Requested: $ __________
Simultaneous (Advanced) Funding Requested: ☐ Yes ☐ No
Simultaneous Amount being Requested: $ __________

YOUR REQUEST SHOULD INCLUDE COPIES OF THE FOLLOWING INFORMATION: (IF APPLICABLE)

- Member Claim Form
- Copy of Hour Bank/Dollar Bank
- Proof of Premium Payments
- COBRA Election form & Proof of payment Medicare
- Medicare Card EOB/Claim checks/Registers
- Deductible/Coinsurance Proof of satisfaction Divorce or Separation Decrees or Court Orders
- Complete Paid Claims Detail/History Report
- Itemized Bills/Electronic Claim Data
- R&C Calculations
- Precertification Forms
- Hospital Audits/Reviews
- Hospital Records
- Large Case Management Reports
- Cumulative paid claims report
- Investigative materials to support claim:
  - Physician’s Statements
  - Subrogation information
  - Work Comp information
  - Accident Details (police report, etc.)

TPA/Claims Administrator Name: ________________________________
Address: ____________________________________________________
Phone: _______________ Fax: _______________ E-Mail: _______________

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ATTACHED FRAUD NOTICE, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

Authorized Signature: ____________________________ Date: ____________

SUBMIT TO:

THE UNION LABOR LIFE INSURANCE COMPANY
3403 Colesville Road, Suite 1300
Silver Spring, MD 20910
Toll Free Phone: 1-800-328-5837 • Fax: 1-240-682-6920 • E-mail: stoplossclaims@ullico.com
SUBSEQUENT SPECIFIC
Claim #_____
Stop Loss Claim Form

FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Arizona: 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 and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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.

California: For your protection California Law requires the following to appear on this form. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurance company 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.

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.

Georgia, Kansas, Oregon, Vermont: Any person who with intent to defraud or knowing that he/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.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.
Maine, Tennessee, Washington: 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.

Maryland: 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.

Nebraska: 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 materially false or deceptive statement is guilty of insurance fraud.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.

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.

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For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.
## MONTHLY AGGREGATE ACCOMMODATION
### REIMBURSEMENT FORM

**Plan Sponsor (Group) Name:**

**Contract Basis:**

**Effective Date:**

**Policy #:**

**Expiration Date:**

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>A</td>
<td>Total Paid Claims through ___ / ___ / _____</td>
<td>$__________</td>
</tr>
<tr>
<td>B</td>
<td>Less: Claims paid outside the Aggregate Contract</td>
<td>$__________</td>
</tr>
<tr>
<td>C</td>
<td>Less: Claims exceeding specific deductibles/loss limit</td>
<td>$__________</td>
</tr>
<tr>
<td>D</td>
<td>Net Claim</td>
<td>$__________</td>
</tr>
<tr>
<td>E</td>
<td>Year-To-Date Attachment Point through ___ / ___ / _____</td>
<td>$__________</td>
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<tr>
<td>F</td>
<td>Year-To-Date Minimum Annual Attachment Point* through ___ / ___ / _____</td>
<td>$__________</td>
</tr>
<tr>
<td>G</td>
<td>Excess of attachment Point</td>
<td>$__________</td>
</tr>
<tr>
<td>H</td>
<td>Less: Total Previous Reimbursements</td>
<td>$__________</td>
</tr>
<tr>
<td>I</td>
<td>Total amount of accommodation requested**</td>
<td>$__________</td>
</tr>
</tbody>
</table>

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* To calculate the Year-To-Date Minimum Annual Attachment Point (F), divide the annual Minimum Attachment Point (Minimum Aggregate Deductible) by 12, then multiply by the number of months that the accommodation has been in effect.

** Total amount of accommodation requested (I) will be line D less the higher of line E or F, less any amounts listed on H.

---

### PLEASE READ BEFORE SIGNING

Monthly Deductible Advance Reimbursement [MDAR] requests must be received within 15 days following the end of the month for which the accommodation is requested.

Enclosed are our Paid Claims Analysis (showing the incurred date of each loss, date of payment, amount of each payment and payee) and the Monthly Loss Summary Report (showing monthly census and claims).

I hereby certify that all checks totaling the amount entered on item A above, have been mailed to the payee.

I CERTIFY FURTHER THAT I HAVE READ AND UNDERSTAND THE ATTACHED FRAUD NOTICE, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

---

**Authorized Signature**

**Title**

**Date**

**TPA/Administrator**

**Address**

**Phone**

**City, State, Zip**

**Fax**

**Email Address**

---

Page 1 of 3

ULL-SLYRBAGG-0814
FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Arizona: 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 and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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.

California: For your protection California Law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: 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.

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.

Georgia, Kansas, Oregon, Vermont: Any person who with intent to defraud or knowing that he/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.

Indiana: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

Kentucky: Any person who knowingly and with intent to defraud an insurance company or other person files a 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.
Maine, Tennessee, Washington: 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.

Maryland: 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.

Nebraska: 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 materially false or deceptive statement is guilty of insurance fraud.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.

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.

North Carolina: Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Oklahoma: 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.

Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 include imprisonment, fines and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits.
YEAR END AGGREGATE
Claim Form

Plan Sponsor (Group) Name: ____________________________ Policy #: ____________________________

Contract Basis: __________ Effective Date: __________ Expiration Date: __________

J. Total Paid Claims $ ______________________
   K. Less: Claims paid outside the Aggregate Contract $ ______________________
   L. Less: Claims exceeding specific deductibles/loss limit $ ______________________
   M. Net Claim $ ______________________
   N. Year-To-Date Attachment Point [Monthly Accommodations] $ ______________________
   O. Minimum Annual Attachment Point [Minimum Aggregate Deductible] $ ______________________
   P. Excess of attachment Point $ ______________________
   Q. Less: Total Previous Reimbursements $ ______________________
   R. Reimbursement Due $ ______________________

PLEASE INCLUDE THE FOLLOWING TO AVOID DELAY:
1. Paid Claim Analysis Report showing name of claimant, incurred date, charge, payment amount and date
2. Eligibility listing which identifies birth date, effective date, termination date and coverage type
3. Proof of funding (including monthly bank statements and/or deposit slips)
4. Void/Refund report
5. Benefit/Service Code report
7. Specific Report showing claimants have exceeded the Specific Deductible/Loss Limit
8. Payments made outside the Aggregate Contract (i.e., Dental, Weekly Income, Vision, etc)
9. Yearly Check Register
10. Outstanding overpayments and subrogation issues
11. Rx invoices with detail listing (if covered under the aggregate contract)

PLEASE READ BEFORE SIGNING
I hereby certify that, to the best of my knowledge, after reasonable inquiry: (1) that the information stated herein is correct; (2) that the claim has been processed and is eligible in accordance with the Schedule of Benefits/Employee Benefit Plan; and (3) that all the indicated expenses have actually been unconditionally paid on behalf of the Plan as required by the Stop Loss Contract.

I CERTIFY FURTHER THAT I HAVE READ AND UNDERSTAND THE ATTACHED FRAUD NOTICE, THAT THE ABOVE INFORMATION IS CORRECT AND THAT THE CLAIMS HAVE BEEN PAID IN ACCORDANCE WITH THE PLAN DOCUMENT.

YOU MUST FILE REIMBURSEMENT REQUESTS WITHIN 90 DAYS AFTER THE END OF THE TIME SPECIFIED FOR PAYMENT OF CLAIMS UNDER THE STOP LOSS POLICY. FAILURE TO DO SO WILL RESULT IN CLAIM DENIAL.

Authorized Signature ____________________________ Title ____________________________ Date ____________________________

TAP/Administrator ____________________________ Address ____________________________

Phone ____________________________ City, State, Zip ____________________________

Fax ____________________________ Email Address ____________________________
FRAUD NOTICE TO INCLUDE ON EACH CLAIM/APPLICATION FORM

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of 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.

Arizona: 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 and civil penalties.

Arkansas, Louisiana, Rhode Island, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of 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.

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WORK STATUS QUESTIONNAIRE

This information is needed in order to verify that the claimant's benefit continuation during the absence from work was in accordance with the continuation of coverage requirements outlined in the Summary Plan Description (SPD). Please review the information below and provide the necessary documentation.

Date: _____________________________

RE: Claimant: ________________________, [Employee or Dependent]

Employer /Fund Name [Policyholder]
Stop Loss Group Number [Policyholder Group Number]
Stop Loss Effective Date [Policyholder Effective Date]

This information is needed in order to verify that the claimant's benefit continuation during the absence from work was in accordance with the continuation of coverage requirements outlined in the Summary Plan Description (SPD). Please review the information below and provide the necessary documentation.

1) Has the employee missed any work due to illness/injury within the last 12 months? Please check: □ Yes □ No

If yes, please provide the actual dates [MM/DD/YY] for the following:

a. When was the last day the employee was actively at work? ______/______/______
b. What was the date the employee returned to work? ______/______/______
c. What is the employee’s Hire Date? ______/______/______
d. What is the employee’s Original Effective Date of Coverage? ______/______/______

2) Sick Days: For the time missed from work, what were the number of sick days used and what were the dates of the sick time?

   a. Total # sick days used __________________

   b. Dates of sick time:

      i. From ______/______/______ To: ______/______/______

      ii. From ______/______/______ To: ______/______/______

      iii. From ______/______/______ To: ______/______/______

3) Vacation Days: For the time missed from work, what were the number of vacation days used and what were the dates of the vacation time?

   a. Total # vacation days used __________________
b. **Dates of vacation time**
   i. From _____/_____/_______ To: _____/_____/_______
   ii. From _____/_____/_______ To: _____/_____/_______
   iii. From _____/_____/_______ To: _____/_____/_______

4) How is the employee's coverage being continued under the Plan during his/her illness or injury? (Please select from one of the following.)

   a. **Employee is Actively at Work**
      Yes _____ No _____

   b. **Employee is Retired**
      [Indicate Date Retired] _____/_____/_______
      i. Premiums are paid by: (Please check only one)
         □ Employee □ Employer □ Both

   c. **Family Medical Leave Act (FMLA)**
      [Indicate]
      i. Effective Date _____/_____/_______
      ii. End Date _____/_____/_______
      iii. Total Hours Scheduled to Work: _______ Hours
      iv. *Premiums are paid by: (Please check only one)
         □ Employee □ Employer □ Both

   d. **Medical/Disability Leave of Absence (LOA)**
      i. Effective Date _____/_____/_______
      ii. End Date _____/_____/_______
      iii. *Premiums are paid by: (Please check only one)
         □ Employee □ Employer □ Both

   e. **COBRA**
      i. Effective Date _____/_____/_______
      ii. End Date _____/_____/_______
      iii. Qualifying Event ______________________________________
      iv. How are Premiums paid? (Please check only one)
         □ Monthly □ Quarterly □ Annually
WORK STATUS QUESTIONNAIRE

Please supply supporting documentation if employee is on FMLA Leave of Absence (LOA) or COBRA, including any of the following that apply:

- Employee Handbook which explains the FMLA or LOA policy;
- Proof of Premium Payments during leave
- COBRA Election Form
- Proof of COBRA Premium Payments.
- Banked Hours – Please provide copy of Banked Hours and/or verification of self-pay premiums.

_________________________
Signature & Date

_________________________
Authorized Signatory (Company & Title)

_________________________
Telephone Number
THIRD PARTY LIABILITY QUESTIONNAIRE

Please submit this form to:
The Union Labor Life Insurance Company

8403 Colesville Road
Silver Spring, MD 20910
202.682.0900

The Ullico Family of Companies

Member’s Name: ________________________________
Claimant’s Name: ______________________________
Health ID#: ________________________
Date of Accident/Injury: _______________________
Plan Name: _________________________

Dear Patient:

In order to process your insurance claim we ask that you answer the following questions.

(The insurance company will not pay on an accident or injury until proof has been shown of a third party liability.)

1) Is your medical problem the result of an injury or accident? □ Yes □ No
2) If your answer is NO, please sign the form and return it to the reception desk.
3) If your answer is YES, please continue.
4) Describe how, when, and where your accident or injury occurred: _______________________________________________________

5) Is your accident or injury Auto related? □ Yes □ No
   If YES, complete the following:
   a. Will you be filing /seeking reimbursement from your/another Auto Insurance Company? □ Yes □ No
   b. Automobile insurance coverage: ___________________________ Claim#: ___________________________
   c. Address of Insurance Company: ________________________________
   d. Phone Number of Insurance Company: __________________________
   e. Name, address, and telephone number of the driver cited or responsible for the accident: ________________________________

6) Did the accident or injuries occur at your home? □ Yes □ No
   a. Will you be filing /seeking reimbursement from your/another Home Owners Insurance Company? □ Yes □ No
   b. Name of your Homeowners Insurance Company, address, and phone number: ________________________________

7) Did the injury happen at another location? □ Yes □ No
   a. Please give the Name, Address, and Phone Number: ________________________________
   b. Will you be filing /seeking reimbursement from another Insurance Company? □ Yes □ No

SOLUTIONS FOR THE UNION WORKPLACE | ESSENTIAL INSURANCE | INVESTMENTS
8. Have you contacted an attorney?  □ Yes  □ No

If YES, please give us the Name, Address, and Phone number of your attorney:

Name: ____________________________
Address: ____________________________
Phone Number: ____________________________

Authorized Signature: ____________________________
Date: ____________________________

SUBMIT TO:
THE UNION LABOR LIFE INSURANCE COMPANY
Stop Loss Claims Unit
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910

Toll Free Phone: 1-800-328-5837 • Fax: 1-202-682-6920 • E-mail: stoplossclaims@ullico.com

Member’s Name: ____________________________
Claimant’s Name: ____________________________
Health ID#: ____________________________
Date of Accident/Injury: ____________________________
Plan Name: ____________________________
The Certificate of Insurance issued to you contains provisions for Subrogation and third party Right of Recovery. These provisions mean that the Company shall be subrogated to all rights of recovery which any insured Person may acquire as a result of an accident, Injury, or Sickness for which another party is liable and for which we pay benefits to the extent of such benefits paid. In case, the Insured Person is deemed to assign all rights of recovery to us, and will be required to pay back to us amounts received from the liable party (or the liable party's insurer), not to exceed the total benefits provided by us.

In acceptance of this health insurance coverage, the Insured Person agrees to furnish any necessary information and complete documents needed by us in order to enforce the right to subrogation. Further, the Insured Person agrees not to take any action that would prevent us from pursuing this right of subrogation.

I acknowledge and agree that reimbursement of medical benefits received under this Certificate of Insurance is required in the event an Insured Person receives a settlement, judgment or other award from a liable third party. I further warrant that no action will be taken that would prejudice the Company’s recovery rights.

Authorized Signature: ___________________________ Date: ______________________

SUBMIT TO:

THE UNION LABOR LIFE INSURANCE COMPANY
Stop Loss Claims Unit
8403 Colesville Road, 13th Floor
Silver Spring, MD 20910
Toll Free Phone: 1-800-328-5837 • Fax: 1-202-682-6920 • E-mail: stoplossclaims@ullico.com
SUBROGATION AGREEMENT

I (we) as participant/eligible dependent/eligible beneficiary understand that, in accordance with the provisions of the Plan of the [Fund], specifically the section entitled “Subrogation of Benefits”, if payments are made by the Fund for any treatment, service, benefit, or disability because of injury to, death of, or illness of the undersigned or an eligible dependent for which I or my eligible dependent or my eligible beneficiary may have a lawful claim, demand, or right against a third party or parties (including an insurance carrier) for indemnification, damages, or other payment with respect to such injury, sickness, or death, that I, my eligible dependent, or my eligible beneficiary is obligated to subrogate such claim, demand, or right to the Fund to the full and complete extent of payments made from and under and pursuant to the Plan.

In consideration of payments made under the Plan for treatment, service, disability, or death and to the extent of such payments made but not in excess of the total proceeds of any recovery, if I or my eligible dependent or eligible beneficiary receive any recovery based upon a claim against anyone for me, my eligible dependent, or my eligible beneficiary, then I (we) specifically agree to reimburse the Fund from the proceeds of such recovery from a third party or parties to the full extent of all monies paid by the Fund on behalf of me, my eligible dependent, or my eligible beneficiary.

This agreement was dated and signed this, ______ day of ____________, 20____.

________________________________________   ________________________________________
Signature of Member                  Member’s Social Security Number

________________________________________   ________________________________________
Signature of Eligible Dependent    Signature of Eligible Beneficiary

State of ________________________________  County of ________________________________

SS: Before me the undersigned, Notary Public for ________________________________ County, State of ________________________________, personally appeared ____________________, and acknowledged the execution of this instrument this ______ day of ____________, 20____.

________/_____/______
Notary Public:
My commission expires:

Enclosed is a copy of a document entitled “Subrogation Agreement”. A Subrogation A
XI. INSURANCE FRAUD AND FRAUDULENT ACTIVITIES

It is the policy of The Union Labor Life Insurance Company to detect, investigate and refer suspected fraudulent insurance activities. The Union Labor Life Insurance Company recognizes that insurance fraud can have a significant impact on the cost of doing business and that reducing both the cost and frequency of fraudulent activity is in the best interest of both the Company and its customers.

We will take a proactive approach in thoroughly investigating suspicious claims and submitting suspected fraud files to the appropriate Department of Insurance Fraud Bureau and/or law enforcement agency designated by specific state regulation.

The Union Labor Life Insurance Company has contracted with an anti-fraud investigative service provider that acts as its Special Investigative Union (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag event, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling. The list of fraud related indicators and red-flag events and the procedures for referring suspected fraudulent activity are included in the attached Fraud Policies and Procedures.
Fraud Policy and Procedures

Ullico Casualty Company       NAIC# 37893
The Union Labor Life Insurance Company     NAIC# 69744
Ullico Life Insurance Company      NAIC# 86371

(The above will hereinafter be referred to as “the Company”)

Contacts:

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Richard LaRocque</td>
<td>VP, Corporate Compliance and Counsel</td>
</tr>
<tr>
<td>Ullico Inc.</td>
<td>1625 Eye Street, NW</td>
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<tr>
<td></td>
<td>Washington, DC 20006</td>
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<td></td>
<td>Ph: 202-962-8951</td>
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<td>Fax: 202-682-6784</td>
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<td></td>
<td>Email: <a href="mailto:rlarocque@ullico.com">rlarocque@ullico.com</a></td>
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<td>Christine Mullen</td>
<td>AVP, Compliance</td>
</tr>
<tr>
<td>Ullico Inc.</td>
<td>8403 Colesville Road</td>
</tr>
<tr>
<td>The Union Labor Life Insurance Company</td>
<td>Silver Spring, MD 20910</td>
</tr>
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<td>Ullico Life Insurance Company</td>
<td>Ph: 202-682-7928</td>
</tr>
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<td>Fax: 202-682-4682</td>
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<td>Email: <a href="mailto:cmullen@ullico.com">cmullen@ullico.com</a></td>
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<td>Christopher Noland</td>
<td>AVP, Compliance</td>
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<td>Ullico Inc.</td>
<td>1625 Eye Street NW</td>
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<tr>
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<td>Washington, DC 20006</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td>Fax: 202-682-6784</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:cnoland@ullico.com">cnoland@ullico.com</a></td>
</tr>
<tr>
<td>Valerie Beebe, FCLS</td>
<td>SIU Compliance Manager</td>
</tr>
<tr>
<td>G4S Compliance &amp; Investigations</td>
<td>910 Paverstone Drive</td>
</tr>
<tr>
<td></td>
<td>Raleigh, NC 27645</td>
</tr>
<tr>
<td></td>
<td>Ph: 803-883-9000</td>
</tr>
<tr>
<td></td>
<td>Fax: 803-883-9000</td>
</tr>
<tr>
<td></td>
<td>Email: <a href="mailto:valerie.beebe@usa.g4s.com">valerie.beebe@usa.g4s.com</a></td>
</tr>
</tbody>
</table>

This document contains information that is confidential and proprietary in nature. No portion of this document, in whole or in part, may be reproduced by any means, manual, electronic or mechanical, and it is not to be disclosed, shared, or otherwise provided to individuals or organizations outside of our Company without the express written consent of the Company.
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Overview

The purpose of these procedures is to provide a guideline to detect, investigate and refer suspected fraudulent insurance activities. It is expected that the adoption and implementation of these procedures will serve to protect the Company's assets and control insurance costs by providing a framework for the appropriate investigation of questionable claims and other potentially fraudulent acts perpetrated against the Company. These procedures are only a guide and do not purport to address all of the types of fraudulent activity that can occur in insurance transactions. In addition, they are not intended to detract from the prerogatives of those in a management position in making sound decisions. The intent of these procedures is to provide a guide that will assist in the decision making process and form the basis for consistent action in the detection, investigation and referral of suspected fraudulent claims and insurance transactions.
1. **FRAUD POLICY**

It is the policy of the Company to proactively and aggressively deter, detect, and investigate internal and external insurance fraud. The Company recognizes that insurance fraud can have a significant impact on the cost of doing business and that reducing both the cost and frequency of fraudulent activity is in the best interest of both the Company and its customers. We are steadfast in providing thorough training to our personnel to increase their knowledge and awareness in the detection and prevention of fraudulent insurance acts, which may include, but is not limited to the following: staging phony accidents, filing fraudulent claims, exaggerating an injury or loss, billing for services not rendered, billing for unwarranted services, premium avoidance, internal fraud and misclassification of workers or concealment of payroll.

We will take a proactive approach in thoroughly investigating suspicious claims and submitting suspected fraud files to the appropriate Department of Insurance Fraud Bureau and/or law enforcement agency designated by specific state regulation; or in the absence of a state regulation and/or fraud bureau to the appropriate federal, state or local prosecuting authority.

Our fraud policy applies to all lines of business written by the Company, which currently include Surety, Inland Marine, Workers’ Compensation, Property and General Liability, Auto, Professional Liability and Life, Accidental Death & Dismemberment, Disability, Group Annuity, Stop Loss, Hospital Indemnity and others. In furtherance of this policy, we have developed and implemented a corporate anti-fraud strategy that is aimed at effectively combating insurance fraud.

The Company has contracted with an anti-fraud investigative service provider that shall act as its Special Investigations Unit (SIU). The Company will first identify those matters that exhibit fraud related indicators, red-flag events, and situations or behaviors indicative of fraud schemes. Those matters identified will then be directed to the SIU for specialized handling.

The Company, together with the SIU, will review, analyze and investigate potentially fraudulent activities. The Company will then use its professional discretion to ascertain the validity of the claims presented. Where state mandates exist as to reporting, investigation, and preparation of fraud referrals, the Company will ensure that all mandates are fulfilled.
2. FRAUD

2.1 Definition of Fraud

The definition of insurance fraud may vary slightly from state-to-state but it is typically defined as "An act or omission committed by a person who knowingly, and with intent to defraud, commits, or conceals any material information" in order to obtain a benefit or advantage to which that person is not otherwise entitled.

Fraudulent activity can include but is not limited to, presenting false information concerning a fact material to one or more of the following: (1) an application for the issuance or renewal of an insurance policy or reinsurance contract; (2) the rating of an insurance policy or reinsurance contract; (3) a claim for payment or benefit pursuant to an insurance policy or reinsurance contract; (4) premiums paid on an insurance policy or reinsurance contract; (5) payments made in accordance with the terms of an insurance policy or reinsurance contract; (6) a document filed with the commissioner or the chief insurance regulatory official of another jurisdiction; (7) the financial condition of an insurer or reinsurer; (8) the reinstatement of an insurance policy.

2.2 Integral Anti-Fraud Personnel

Integral anti-fraud personnel include company personnel who are not directly assigned to its SIU but whose duties may include the processing, investigating, payment or denial of a claim, the processing of applications for insurance and the processing of general insurance transactions. Such personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties. The Company’s integral anti-fraud personnel, as part of their regular duties, are responsible for identifying suspected insurance fraud during the handling of insurance transactions, and referring such suspicious activity to their supervisor and/or compliance department.

2.3 Detecting Suspected Fraud

This refers to the ability to detect evidence of possible insurance fraud. Integral anti-fraud personnel must be knowledgeable of the various state and federal insurance anti-fraud laws and regulations as well as laws related to other conduct commonly associated with fraudulent insurance transactions. More fundamentally, the identification component refers to the ability to recognize which claims and other insurance transactions reflect circumstances or events that support an inference that insurance fraud may have or might be occurring.

Once evidence of suspected fraud has been properly confirmed, the representatives handling the claim or insurance transaction, in conjunction with their supervisor and compliance department, should determine whether the suspicion is reasonable and appropriate for referral to the SIU.

2.4 Referral of Suspected Fraud

All suspected fraudulent activity must be referred to the SIU for investigation and reporting to the appropriate state bureau and/or agency.
3. SPECIAL INVESTIGATIONS UNIT (SIU)

3.1 Definition of SIU

A SIU is a unit or division established by an insurer to investigate suspected insurance fraud. A SIU should be adequately staffed with individuals who are knowledgeable and experienced in general insurance practices, analysis of claims for patterns of fraud, current fraud trends, fraud education and training and any other criteria indicating possible fraud. The SIU should have the ability to conduct effective investigations of suspected insurance fraud, be familiar with state fraud regulations and be able to perform all functions and activities set forth in such regulations.

3.2 The Company SIU

To fulfill its statutory requirements, and exceed its quality standards, the Company contracts with G4S Compliance & Investigations (G4S), an international anti-fraud investigative service provider, that shall act as its Special Investigation Unit (SIU).

Company representatives, integral to the insurance fraud detection and identification process, will identify those matters that exhibit fraud related indicators, red flags, red flag events, and situations or behaviors demonstrative of suspected fraud schemes and activities. Those matters identified are directed to the SIU for specialized handling to be completed in accordance with the Detection, Review and Referral Policy outlined in this Plan.

The Company's Special Investigation Unit program is a comprehensive strategy designed to assist our integral anti-fraud professionals, including claims, underwriting, and other designated personnel with preventing, detecting and investigating insurance transactions containing suspected fraud. The Fraud Prevention & Detection Plan also intends to minimize claim exposures through enhanced information verification and intelligence capabilities.

The Special Investigation Unit was created to provide the integral personnel with a national investigative program managed and staffed by experienced professionals. The Company's contracted and outsourced investigations company, G4S, provides Special Investigation Services, Surveillance, Fraud and Claim Investigation Training, SIU Compliance & Reporting, Auditing and Consulting, and other related services.

The Company, including its SIU, shall review, analyze, and investigate suspected fraudulent activities. The Company will utilize its experience and professional discretion to validate the information presented and the accuracy of the claim, application, or other suspect insurance transaction.

Where mandated by state statute and/or regulations for the reporting of suspected insurance fraud, filing of fraud plans or annual reports, and anti-fraud education, the Company will ensure good faith compliance to fulfill the requirements.

The VP, Corporate Compliance and Counsel, the Assistant Vice President, Compliance Property and Casualty and the Assistant Vice President, Compliance Life and Health act as the liaisons to the SIU. They monitor the referral of any suspicious activity to the SIU. The SIU is responsible for thoroughly investigating these matters and reporting such matters to the appropriate law enforcement authorities.
The SIU's investigations of suspicious activity may include:

- Analysis of referred case files and development of an investigation plan;
- Compiling of relevant information for the commencement of civil litigation and/or the referral to the appropriate regulatory and/or law enforcement agency;
- Documentation of all investigative activity;
- Preservation of relevant evidence;
- Conducting of interviews and recorded statements of insureds, claimants, witnesses, and other persons who may have information relevant to the suspected fraudulent activity;
- Preparation of investigative reports;
- Attending examinations and supporting legal counsel involved in SIU investigations;
- Creation and delivery of anti-fraud education/training.
4. DETECTION OF COMPANY-RELATED FRAUD

Ullico's Audit Department, acting under the supervision of Ullico's Risk Management Group, is responsible for the detection of company-related fraud, including insurance fraud. The Audit Department reports such matters to the Vice President of Risk Management, the Chief Compliance Officer and General Counsel and the Audit Committee of the Ullico Board of Directors as applicable. The Audit Department in cooperation with the Law Department and the Human Resources Department is charged with the responsibility of overseeing the investigation of suspected theft, embezzlement and other fraudulent business practices. The Chief Compliance Officer and the Vice President of Risk Management are responsible for notifying law enforcement agencies of suspected theft, embezzlement and other fraudulent incidents. The Chief Compliance Officer and General Counsel and the Vice President of Risk Management are responsible for cooperating with law enforcement agencies in the investigation and prosecution of referred matters. Ullico requests restitution in criminal cases.

The Audit Department periodically audits claims and underwriting procedures, and conducts random reviews of closed claims files. The Audit Department also conducts periodic audits of the claims adjudicative process, including audits of the processes employed to detect suspicious claims activity. The audits are intended to ensure that proper procedures and controls are in place to detect and prevent fraud. Such audits also are intended to aid related criminal prosecutions and civil litigation in which restitution is sought. The Audit Department coordinates the scheduling and preparation of such audits with the Group Life and Health and Property and Casualty areas.

Union Labor Life's group field auditors audit the premium and eligibility information of the group policyholders and insurance producers to verify proper amounts are calculated and remitted to the Company.

Ullico Casualty periodically audits underwriting procedures of all its Managing General Underwriters (MGUs) and claims processes of its Third Party Administrators (TPAs), and also reviews all general insurance and claims transactions processed by its in-house integral fraud personnel. Ullico Casualty performs voluntary premium audits, and its contracted field auditors perform physical audits of its workers' compensation policyholders to verify classifications and exposures are accurately reported. These audits are intended to ensure that all underwriting and claims procedures are being followed and proper procedures and controls are in place to detect and prevent fraud.

Ullico also conducts background investigations of prospective employees prior to hiring. The background investigations focus on such diverse areas as the prospective employees' financial affairs, employment histories, criminal records, if any, participation as a party in civil litigation and personal references.

Ullico also maintains a third party vendor web based ethics site that allows employees to report anonymously any irregular or fraudulent issues as they arise. These issues may be reported through the web site or by telephone using the Compliance Hotline.

To protect data integrity and to prevent fraud, Ullico requires that its employees change their passwords at 60-day intervals and automatically expires unchanged passwords every 60 days. In addition, Ullico check stock is kept in a locked and secure cabinet. All company checks require two signatures.

Instances where insurance fraud or suspect activity is identified are referred to our contracted SIU, G4S Compliance & Investigations.

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5. EDUCATION AND TRAINING

All of the Company’s employees, MGUs and TPAs must receive new employee anti-fraud training within 90 days of their first day of employment. The SIU also provides annual anti-fraud training and educational materials about the prevention, identification and detection of insurance fraud to the Company’s integral anti-fraud personnel, including its MGUs and TPAs. Anti-fraud training also addresses the objectives, functions and responsibilities of the SIU, and its interaction with government entities such as state insurance departments and law enforcement agencies.

The SIU makes available to the Company personnel such resources as investigative techniques, database information, analysis of insurance fraud practices and fraud trends. The SIU also provides information regarding applicable state and federal law and responds to individual requests for assistance and support.

The Company also reviews and monitors the fraud detection, anti-fraud training and management program of its MGUs and TPAs.
6. DETECTION, REVIEW & REFERRAL POLICY

The Detection Review and Referral Process works as follows:

A. As integral anti-fraud personnel, you have the duty to recognize and investigate suspected fraud activity. Through training, you will recognize potential fraudulent activity including any “Red Flags”. When this occurs, you must immediately notify your supervisor or the appropriate compliance contact of the circumstances leading you to believe a fraud is being committed. Your supervisor or the compliance coordinator will assist you in your initial investigation and where appropriate refer the matter to the SIU for further action as outlined below.

B. SIU Cases may be assigned in one of five ways **:

1. **Internet** – Complete the Referral Form on the SIU website;
2. **Email** – Complete the SIU Referral Form (see Appendix 1) and attach to an email and send to siumanager@usa.g4s.com;
3. **Fax** – Complete the SIU Referral Form and Fax;
4. **Phone** – Call the SIU on the toll-free number;
5. **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client’s surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

- **Eastern & Central**: Voice – [800] 927-0456
  Fax – [800] 927-2239
- **Western**: Voice – [888] 501-7017

** (NOTE: Ullico requires management approval prior to submission of all SIU assignments.)

C. The following information should be provided by the referrer upon assignment to maximize the benefit of performing an investigation and to protect the adjuster from accusation of potential malicious prosecution charges by the suspect. A Fraud Referral Checklist identifying additional information that may be included in the referral is attached as Appendix 4.

1. Claim Number /Policy Number
2. Red Flags/reason for suspicion of possible fraudulent activity

D. G4S will confirm receipt of each electronic assignment via an email to the requesting adjuster or referrer.

E. G4S will then arrange to review a complete copy of the policy, application and/or claim file, either in person (preferred method) or by having a complete copy of the file, both paper and electronic, sent to the SIU Investigator.
7. FRAUD INDICATORS (“RED FLAGS”)

Determining the possibility of fraud in any insurance transaction is facilitated when the integral anti-fraud personnel is familiar with various fraud indicators. The indicators in the appendices should help isolate those insurance transactions that merit closer scrutiny. No one indicator by itself is necessarily suspicious. Even the presence of several indicators, while suggestive of possible fraud, does not mean that fraud has been committed. Indicators of possible fraud are “Red Flags” only, not actual evidence.

A current list of “Red Flags” is available at anytime for your reference. Some common fraud indicators are included in Appendix 3 as a reference.

For any additional questions, please contact your supervisor and/or your compliance department.
Appendix 1 – Example Investigative Referral Form

Thank you for choosing G4S for your investigative needs!

We would like to make it as easy as possible to refer your files to G4S. Please find below three EASY ways to submit your referrals to G4S:

1. Fill in this form and email to: siumanager@usa.g4s.com
2. Log onto www.cni.g4s.com and go to "Refer a Case to G4S"
3. Log onto www.cni.g4s.com/casetrak and input your user ID and password for access to G4S CaseTrak
4. Fill in this form and fax to: 800-927-2239

If you have any questions regarding this form or your investigation, please feel free to call your local Account Manager for assistance. We look forward to working with you!

Client Information:

<table>
<thead>
<tr>
<th>Your Name:</th>
<th>Due Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company:</td>
<td>Today's Date:</td>
</tr>
<tr>
<td>Address:</td>
<td>Budget:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Date of Loss:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Insured:</td>
</tr>
<tr>
<td>Fax:</td>
<td>Insurance Carrier:</td>
</tr>
<tr>
<td>Email:</td>
<td>Claim/File #:</td>
</tr>
</tbody>
</table>

Assignment Type (Double-Click the box below to check off your type):

- State Fraud Referral Only
- SFR and additional SIU Investigation
- I want to talk to the SIU Manager
- Other

<table>
<thead>
<tr>
<th>Dollar Amount Paid To Date</th>
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<tbody>
<tr>
<td>Dollar Amount of Reserves:</td>
</tr>
<tr>
<td>Dollar Amount of suspected fraud:</td>
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<tr>
<td>Is this file in litigation</td>
</tr>
<tr>
<td>Do you suspect organized ring activity:</td>
</tr>
<tr>
<td>Do you suspect attorney involvement:</td>
</tr>
<tr>
<td>Do you suspect Medical Provider involvement:</td>
</tr>
</tbody>
</table>

Additional Notes:

Claim Type (Double-Click the box below to check off your type):

- Workers’ Compensation
- Auto Liability
- Commercial Liability
- Commercial Theft/Fire/Damage

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**Fraud Policies and Procedures**  
Revised: June 2011

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<td>□</td>
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<td>Auto Theft/Fire</td>
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<td>□</td>
<td>Homeowner Liability</td>
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<td>Homeowner Theft/Fire/Damage</td>
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<td>Disability</td>
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<td>Life/Health</td>
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<td>General Liability</td>
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<td>Other (Please explain)</td>
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</table>

**FACTS OF LOSS**

**LOSS LOCATION**

Street Address

County or Parish

City/State/Zip

Please provide the below information on the Insured

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<thead>
<tr>
<th>Name:</th>
<th>SSN:</th>
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</thead>
<tbody>
<tr>
<td>Address:</td>
<td>DL # &amp; State:</td>
</tr>
<tr>
<td>City/State/Zip:</td>
<td>Sex:</td>
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<td>Home Phone:</td>
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<td>Address:</td>
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<td>DOB:</td>
<td>City/State/Zip:</td>
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**Involved Party #2 (Double-Click the box below to check off all that applies):**

- [ ] Claimant
- [ ] Insured
- [ ] Witness
- [ ] Attorney
- [ ] Medical Provider
- [ ] Other

I suspect this person or company is committing insurance fraud.

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<th>SSN:</th>
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<td>City/State/Zip:</td>
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## Involved Party #3 (Double-Click the box below to check off all that applies):

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<th>Witness</th>
<th>Attorney</th>
<th>Medical Provider</th>
<th>Other</th>
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- I suspect this person or company is committing insurance fraud.

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| DL # & State:  |          |         |         |          |                  |       |
| Sex:           |          |         |         |          |                  |       |
| Race:          |          |         |         |          |                  |       |
| Occupation:    |          |         |         |          |                  |       |
| Employer:      |          |         |         |          |                  |       |
| Address:       |          |         |         |          |                  |       |
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## Involved Party #4 (Double-Click the box below to check off all that applies):

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<th>Witness</th>
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<th>Medical Provider</th>
<th>Other</th>
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- I suspect this person or company is committing insurance fraud.

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| Occupation:    |          |         |         |          |                  |       |
| Employer:      |          |         |         |          |                  |       |
| Address:       |          |         |         |          |                  |       |
| City/State/Zip: |         |         |         |          |                  |       |

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**PROVIDE A DETAILED SUMMARY OF WHY YOU SUSPECT THE CLAIM OR UNDERWRITING FILE IS SUSPICIOUS:**

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Fraud Policies and Procedures
Revised: June 2011
Appendix 2 – SIU Program Contacts

**G4S SIU PROGRAM CONTACTS**

Please contact the individuals listed below with any questions concerning the Special Investigation Unit and/or the Company Anti-Fraud Plan & Program.

**G4S Compliance & Investigations, Inc.**
910 Paverstone Drive  
Raleigh, NC 27615  
(800) 927-0456  
www.g4s.us/investigations

**Valerie Beebe, FCLS**  
Regulatory Compliance Manager  
G4S - SIU  
valerie.beebe@usa.g4s.com  
(704) 560-6203

**SIU Leadership Team**

- **Larry G. Henning, CFE CIFI**  
  Senior Vice President - SIU  
  larry.henning@usa.g4s.com  
  (336) 830-9660
- **Brett Douglas, CFE, CIFI**  
  Vice President SIU & Western Region  
  bretton.douglas@usa.g4s.com  
  (916) 627-1632
- **Valerie Beebe, FCLS**  
  Regulatory Compliance Manager  
  valerie.beebe@usa.g4s.com  
  (704) 560-6203
- **David Bond, FCLS**  
  Vice President – SE Region  
  david.bond@usa.g4s.com  
  (919) 334-9283
- **Kevin Lupton, FCLS**  
  Asst. Vice President – NE Region  
  kevin.lupton@usa.g4s.com  
  (919) 334-9222
- **Scott Finger**  
  Vice President – Midwest Region  
  scott.finger@usa.g4s.com  
  (630) 922-9400

Fraud Policies and Procedures  
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Appendix 3 – “Red Flags”

**Commercial Property**

1. Were there extensive commercial losses at a site where few or no security measures are in effect?
2. Did the loss occur when the security devices fail to work?
3. Are there radically differing accounts of the accident or manner in which the loss occurred?
4. If a commercial loss primarily involves seasonal inventory or equipment, is the claim at the end of the selling season, e.g., ski inventory claimed stolen in the spring, farm machinery stolen in the fall?
5. Do the claimed commercial losses include old, outdated, or otherwise unmarketable inventory?
6. Are the facilities outmoded?
7. Is the claimant approaching retirement age?
8. Would the claimant like to retire?
9. Is the claimant ill?
10. Did the claimant have a renovation loan approved before the loss, but work had not begun?
11. Is the property in receivership or foreclosure?
12. Is a major investment required for a change in technology?
13. Did the loss occurred on a holiday, weekend, or after hours?
14. Were fire doors left open?
15. Were work orders canceled just prior to the loss?
16. Is the business failing to meet production quotas or deadlines?
17. Is the businesses’ inventory obsolete or overstated?
18. Is the businesses’ storage area too small for the amount of claimed inventory?
19. Is the unit value of items overstated on the inventory?
20. Are receipts unnumbered or on generic forms?
21. Do receipts include pre-printed information?
22. Is the claimed loss not directly related to the claimant’s business?
23. Is the business in a bad location or deteriorating neighborhood?
24. Was the property over-insured?
25. Is there evidence that valuable property was recently removed from the premises or relocated to a safer place within the premises?
26. Was there any departure from long-standing routine (failure to activate alarm system; shut-down of sprinkler system; discharge of security guard)?
27. Is there evidence of unlawful entry?
28. Does it appear that evidence of unlawful entry has been manufactured?
29. Is there any indication that the business is having financial difficulties or has immediate need for funds?
30. Is the real property heavily mortgaged?
31. Does business property secure multiple and substantial debts?
32. Is there recent history of late payments or defaults on loans?
33. Do the principals in the business have a history of business failures?
34. Has there been a recent expansion of business facilities that has caused the insured to incur substantial debt or other over extension?
35. Is there an overlapping ownership of related businesses with inventory moving readily between businesses without adequate documentation?
36. Is the economic climate poor for this particular business?

Financial Indicators

1. Has the insured’s business shown decreasing revenue?
2. Does the insured’s business show increasing production costs for labor, materials, sales, and general and administrative overhead?
3. Has new technology made the insured’s current process or equipment inefficient and/or out of date?
4. Is the insured’s business suffering from increased competition?
5. Is the insured’s business producing new products, making inventory obsolete?
6. Have new competitors moved into the insured’s neighborhood?
7. Does the insured’s business require a high level of research and development expenditure?
8. Does the insured’s business reflect a low level of research and development expenditure?
9. Is the insured’s business showing a poor financial position in the industry?
10. Is the insured paying for a costly lease or rental agreement that is not covered by earnings?
11. Has the insured entered into contracts with customers that are not profitable?
12. Has the insured lost key customers?
13. Do the insured’s records show a failure to record depreciation?
14. Do the insured’s inventory records show excessive spoilage or defects?
15. Do the insured’s records show double payments of bills?
16. Does the insured pay personal expenses with corporate funds?
17. Does the insured maintain numerous bank accounts?
18. Do the insured’s bank records show a low or overdraft cash balance?
19. Do the insured’s records reveal poor or negative cash flow from operations?
20. Do the bank records reflect frequent NSF (bounced) checks?
21. Are there large or frequent currency transactions?
22. Do the records reflect a trend in accounts receivable growth?
23. Has the insured pledged assets for multiple loans?
24. Do the books and records reflect hypothetical assets?
25. Do the insured’s records show multiple liens on assets?
26. Are assets insured for more than their fair market value or replacement cost?
27. Does the insured factor accounts receivable?
28. Was inventory removed prior to loss?
29. Did the inventory at time of loss only include slow moving items?
30. Was their overstocking caused by overproduction or obsolete items?
31. Do books and records reflect increased borrowing by the insured?
32. Do books and records reflect large or numerous overdue accounts payable?
33. Do books and records reflect inability to pay current bills for utilities, payroll, or vendors?
34. Do books and records reflect multiple loans to or from officers or employees?
35. Do books and records reflect severe credit limits imposed on the insured by lenders or suppliers?
36. Has the insured reported frequent C.O.D. purchases?
37. Do books and records show payment of bills by cashier, certified check, or money order?
38. Were withholding taxes, payroll taxes, or sales taxes deposited tardily?
39. Has the insured overstated asset value in a proof of loss statement?
40. Is the insured a guarantor or co-maker of a note with loan in default?
41. Was there a sale or auction of assets shortly before the report of the loss?
42. Has the insured acquired excessive business interruption insurance?
43. Do the books and records reflect much litigation against the insured’s business or owners?
44. Do the books and records reflect an extraordinary write-off?
45. Are there bankruptcy proceedings of the owner, firm, or affiliated business?
46. Are there frequent or unusual inter-company transactions with an affiliated company?
47. Does the insured maintain two or more sets of books?
48. Do the books and records contain false or altered documents or records?
49. Does the insured’s business maintain weak internal controls?
50. Has the insured’s business license been revoked or suspended?
51. Are there large, unexplained differences between book and taxable income?
52. Do the books and records reflect duplicate sales invoices?
53. Has the insured over-documented losses with a receipt for every loss and/or receipts for older items of property?
54. Does the insured’s loss inventory differ significantly from the police department’s crime report?
55. Can the insured recall the place and/or date of purchase for newer items of significant value?
56. Has the insured provided receipt(s) with incorrect or no sales tax figures?
57. Has the insured provided receipts/invoices from the same supplier with sequence numbers in reverse order of purchase dates?
58. Has the insured provided two different receipts with the same handwriting or typeface?
59. Has the insured provided a single receipt with two different handwritings or typefaces?
60. Has the insured provided a credit card receipt with an incorrect or missing approval code?
61. Has the insured provided copies of checks with no coding in the bottom right corner?

**Arson for Profit**

1. Did the fire occur on a holiday or weekend?
2. Did the fire start late at night?
3. Did the fire occur during renovation?
4. Is there an absence of accidental or natural causes at the point of origin?
5. Was there an unusual presence of combustible material on the premises?
6. Was there unusual handling of combustible materials normally present on the premises?
7. Were there multiple separate fires?
8. Was there a fire where there is no natural source of ignition available?
9. Did the fire spread unnaturally?
10. Is there excessive fire damage?
11. Is there evidence of extreme heat?
12. Was the entry for fire fighters blocked by vehicles or contents pushed up against entry doors?
13. Was the view into the structure blocked?
14. Was there a short period of time between exit of occupant and fire?
15. Is this the second fire in same structure?
16. Is there presence of burned or unburned newspapers at point of origin?
17. Was there structural damage prior to the fire?
18. Are the insured’s movements unaccounted for at the time of the loss?
19. Were contents, such as major appliances, removed prior to the fire?
20. Was valuable or sentimental property recently moved to a safe place?
21. Had contents been substituted?
22. Were contents out of place or unassembled?
23. Were personal items or important papers absent?
24. Is there evidence of other crimes?
25. Is the property overinsured?
26. Is the insured under economic duress or will he or she gain some economic advantage from the fire?
27. Do the alleged contents of the structure seem improbable (such as a Picasso oil painting in a low-income apartment)?
28. Is the insured missing receipts, photos, or other evidence of the items allegedly destroyed in the fire?
29. Does the insured have receipts, photos, and documentary evidence of every item allegedly destroyed in the fire?
30. Is the insured unusually calm?
31. Is the claimant suspicious of public officials?
32. Are there large, outstanding utility bills or property taxes?
33. Did the fire alarm, burglar alarm, or sprinkler system fail to work at the time of the loss?
34. Is the property loss site claimed by multiple mortgages or chattel mortgages?
35. Does the contents list include items of high value recently purchased?
36. Does the contents list include serial numbers that owners do not typically record?
37. Is there no proof provided for recent expensive purchases?
38. Is the value of items inconsistent with claimant’s income?
39. Is the face value of policy greater than market value of property?
40. Do receipts show incorrect tax or no sales tax?
41. Are receipts in whole dollar amounts?
42. Are receipts generic with no store logo?
43. Were receipts and owner’s manuals destroyed in the loss?
44. Does the insured indicate distress over prospect of examination under oath?

**Auto Claims**

1. Does physical damage to one vehicle not match the physical damage to other vehicles involved in the same accident?
2. Does the damage to the vehicle appear to have been applied by a blunt object like a light pole, wall, or a hammer rather than by another vehicle?
3. Do the witnesses and parties have conflicting versions of the same accident?
4. Did a third party report the claim?
5. Did the accident occur on private property near the residence of those involved?
6. Does the Vehicle Identification Number (VIN) match the damaged vehicle?
7. Are all damaged vehicles in a reported accident taken to the same repair shop?
8. Are the repair shops used actually equipped to make repairs listed on the estimate?
9. Is there no lien holder listed for an expensive, late model vehicle?
10. Does the owner want to retain salvage of the vehicle?
11. Was the vehicle repaired before the loss was reported?
12. Did the accident occur shortly after one or more of the vehicles was purchased or registered?
13. Is the letter from the lawyer dated the day of the accident or shortly thereafter?

**Life Insurance Fraud**

1. The policy’s effective date is close to the date of death
2. The deceased is not well-known by relatives
3. There are many small policies with coverages that are available in mass offerings, *i.e.*, in magazines and mail-in and television advertisements?
4. The agent’s "loss ratios" are unusually skewed considering the size of the market and the types of people insured
5. There are numerous life insurance policies purchased on the deceased
6. There were different carriers used in securing coverage for no apparent reason
7. The coverage amount is excessive considering the social position of the deceased
8. The claim is made shortly after the expiration of the contestability period
9. Any death within a contestable period
10. Any death with no body recovered
11. Any accidental death under less than open and shut circumstances
12. High dollar policy
13. Policies without investigative confirmation of income
14. Any discrepancies in any document
15. Any question that insured did not know about policy
16. Excessive documentation provided
17. Any doubts about the cause of death
18. Multiple policies not requiring an exam
19. Any possible suicide motives
20. Roommate or boarder arrangements
21. Marital problems – separation or divorce
22. Financial issues
23. Legal issues
24. Death in another country, especially with death certificate and related documentation in another language
25. Increase in coverage amount shortly before death
26. Change of beneficiary shortly before death
27. Death certificate shows a home address that is a great distance from the deceased’s place of work.
28. Group insurance - Employer records show Date Last Worked is the same as date of death, if inconsistent with circumstances of death (cancer diagnosis; died in a nursing home)

29. Group insurance - Deceased's occupation on the death certificate is inconsistent with employer records.

**Disability Income (DI)**

1. Newly covered claimant
2. Group policy without individual underwriting
3. Claimant was self employed or had family business
4. Verification of claimant's pre-event income not completed
5. Declining income or indications it may have been likely to decline
6. Recent increase in coverage
7. Work related issues
8. Eager for settlement
9. Multiple disability income coverage
10. Claimant traveling extensively
11. Home or personal/family issues
12. Employer downsizing, planning layoff, or closing a plant or office around the time of the claim.

**DI Employee Indicators**

1. Employment began shortly before the date of the accident
2. Self-employed claimant
3. Income level incompatible with claimant’s standard of living
4. Income seems inconsistent with occupation
5. Other sources of claimant's income not documented
6. Tax returns not provided by claimant
7. Claimant filed no tax return

**General Indicators of Application Fraud**

1. Unsolicited, new walk-in business, not referred by existing policy holder.
2. Applicant walks into agent's office at noon or end of day when agent and staff may be rushed.
3. Applicant neither works nor resides near the agency.
4. Applicant's given address is inconsistent with employment/income.
5. Applicant gives post office box as an address.
6. Applicant has lived at current address less than six months.
7. Applicant has no telephone number or provides a mobile/cellular phone number.
8. Applicant cannot provide drivers license or other identification or has a temporary, recently issued, or out-of-state driver’s license.

9. Applicant wants to pay premium in cash.

10. Applicant pays minimum required amount of premium.

11. Applicant suggests price is no object when applying for coverage.

12. Applicant’s income is not compatible with the value of vehicle to be insured.

13. Applicant is never available to meet in person and supplies all information by telephone.

14. Applicant is unemployed or self-employed in transient occupation (e.g., roofing, asphalt).

15. Applicant questions agent closely on claim handling procedures.

16. Applicant is unusually familiar with insurance terms or procedures.

17. Application is not signed in agent’s view (e.g., mailed in).

18. Applicant is reluctant to use mail.

19. Applicant works through a third party.

**Workers’ Compensation**

1. The accident occurs late Friday afternoon or shortly after the employee reports to work on Monday morning.

2. The accident is not witnessed.

3. The witnesses to the accident report conflicting version from one another and/or from the employee.

4. Details of the accident are vague or contradictory.

5. The accident is not promptly reported by the employee to the supervisor.

6. The claimed injury coincides with seasonal layoffs, business shutdowns, strikes or personal problems.

7. The claimant is in line for early retirement or has been advised of an upcoming layoff or dismissal.

8. The disability claimed is beyond that normally associated with claimed injury.

9. The injuries are soft-tissue injuries.

10. The employee claims incapacitation; however, is seen in activities that require full mobility.

11. The employee has a history of prior Workers’ Compensation claims.

12. The independent medical examination reveals conflicting medical evidence.

13. The employee is difficult to reach at home at various times throughout the day.

14. Leads from co-workers, ex-spouse or others that the employee has “off the book” employment.

15. Rehabilitation reports indicate the employee is tanned, has good muscle tone, is calloused or shows other signs of work or physical activity.

16. The employee has a history of self employment, has a trade or works in a cash business.

17. The employee is consistently uncooperative.

18. The injured worker is a new hire or working at a family owned business.
19. The employee took unexplained or excessive time off prior to claimed injury.
20. The employee displays a job history of fairly short periods of time.
21. The employee uses addresses of friends, family, or a post office box and/or has no known permanent address and/or moves frequently.
22. The employee's family members know nothing about the claim.
23. The employee was experiencing financial difficulties and or domestic problems prior to submission of claim.
24. The employee is known to have a high risk outside activity, such as skydiving or mountain climbing.
25. An attorney’s letter of representation or letter from a medical facility is the first notice of claim.
26. The attorney's letter of representation is dated the same day of the reported accident or very shortly after.
27. There is a repeated pattern of doctor/attorney referrals; the same doctor and attorney work together on a large volume of claims.
28. The accident or type of injury is unusual for the employee's line of work.
29. Facts regarding the accident are related differently in various medical reports, statements and employer's first report of injury.
30. The employee's version of the accident has inconsistencies.
31. Several of the employee's family members are receiving W/C, Unemployment Compensation, Social Security and/or Welfare, etc.
32. Employee refuses diagnostic procedures to confirm injury, or refuses to attend a scheduled medical exam.
33. Employee's co-workers express opinion that the injury is not legitimate.
34. The employee frequently changes physician or does so after being released to return to work.
35. The medical treatment is inconsistent with injuries originally alleged by the employee.
36. The employee undergoes excessive treatment for soft tissue injuries.
37. Specific “soft tissue” injury develops psychiatric overtones.
38. Employee sends in medical reports which appear to be altered.
39. Surveillance shows employee's activities are inconsistent with physical limitations related in the medical reports and or deposition.
40. The employee is overly pushy, demanding a quick settlement, commitment or decision.
41. The employee is unusually familiar with claims-handling procedures, W/C rules and procedures.
42. The number of days worked and the amount of salary are inconsistent with the employee's occupation.
43. The injured employee disputes the average weekly wage due to additional income (i.e., per diem and/or 1099 income).
44. The injured employee files for benefits in a state other than the principal location of the alleged industrial injury or occupational disease.
45. The employee’s listed occupation is inconsistent with the employer’s stated business.
46. The employee’s address is different than the principal location of the employer other than bordering states.
47. The employee is unable to supply the date, time and/or place of the accident.
48. The employee is unable to supply specific details of the accident.
49. The employee changes the version of the accident after being informed of inconsistencies.
50. The employee provides a cell phone or pager as a primary contact number.

General Indicators

1. A post office box (P.O. Box) is used for the mailing address, rather than a regular street address.
2. The claimant consistently uses overnight express services (such as FedEx) or hand-delivers the claim materials, rather than using the US Postal Service.
3. The claimant requests proof-of-loss forms and instructions on how to file a claim before the loss has actually occurred.
4. The initial claim contact is made by an attorney, or the services of an attorney have been contracted before the claim has been filed with the company.
5. The claimant becomes unusually “pushy” or demanding; insists on prompt action shortly after the claim is filed; or follows up with frequent telephone inquiries regarding the status of the claim. When claim settlement is not quickly offered by the company, the claimant’s immediate response is to threaten legal action or to contact an attorney, threatens to call regulatory authorities (such as the state insurance department), or threatens to “go over the head” of the claims examiner and to report the matter to his or her superiors.
6. The claimant becomes hostile when asked to provide needed documentation to support the claim; or is unwilling to provide authorization for the release of personal or medical information; or refuses to give a written or recorded statement regarding the loss.
7. The coverage amount had been increased shortly before the claim occurred.
8. The loss (claim) occurred within a relatively short period of time, such as three months or less, after the coverage went into effect; or, the loss occurred shortly after the contestable period expired.
9. An inordinate amount of documentation supporting or proving the claim was submitted with the initial claim report, especially when such materials were not specifically requested of the claimant, giving the appearance that the claimant has been through this process previously. The claimant seems inexplicably well-versed in insurance claims procedures and/or medical terminology; or, conversely, has worked for an insurance company or law enforcement agency in the past.
10. After the claim has been initially rejected or questioned for payment, the claimant then submits revised information and/or documentation to further bolster the credibility of the loss.

11. The loss (or the proximate causes for the loss) occurred in a foreign country; the documentation supporting the loss is from foreign hospitals, doctors, police or other governmental agencies; or the death certificate was issued by a foreign government.

12. Incomplete (or vague) answers are given to “key” questions on the proof-of-loss forms. Important details are not included or are “forgotten” until after the claim is questioned.

13. A police report was not completed at the time of the accident, and no reasonable explanation can be given for not doing so.

14. An accidental injury occurred on private property with no witnesses – other than, perhaps, someone who stands to gain financially by the loss and subsequent claim.

15. The medical provider’s or attending physician’s “signature” is hand-stamped, rather than an original signature; or the hand-writing and/or typing on the separate claimant and provider/physician forms are similar.

16. Medical and other claim forms, etc., appear to have been altered or “white out” was used; reports from medical providers are on plain stationery, rather than letterhead paper; misspelled or inappropriate/missused medical and/or legal terminology is used; or photocopied documents appear to include different kinds of typewriter ink or handwriting entries.

17. Medical records have been submitted by the claimant, rather than being sent directly from the physician or other health care provider.
Appendix 4 – Fraud Referral Checklist

Fraud Referral Checklist

A referral of an act of suspected insurance fraud shall contain the following information and data as applicable:

General Information
☐ Complete company name (Ullico Casualty Company, The Union Labor Life Insurance Company)
☐ Complete company address
☐ Referrer's contact information
☐ Name and contact information of defense attorney

Insurance Policy or Claim Information
☐ Type of fraud (i.e. application, premium, producer)
☐ Type of policy (i.e. general liability, commercial auto, workers’ compensation, disability)
☐ Policy or claim number
☐ Name and contact information of claimant or policyholder
☐ Date of loss or injury
☐ Description of loss or injury
☐ Policy state or state where loss or injury occurred
☐ Synopsis of all the facts

Documentation
☐ Red Flags, clearly identified in the referral
☐ Copies of suspected fraudulent documents (i.e. cashed checks, policy documents, declarations pages, correspondence)
☐ Pertinent documentation from claims files (i.e. deposition transcripts, medical records, accident reports, video surveillance)
☐ Contact information of parties of interest
☐ Timeline of events
☐ List of payments made and/or collected

Submitting Fraud Referrals
The Client Representative may refer an assignment by any of the following methods:
  - **Internet** – Complete the Referral Form on the SIU website;
  - **Email** – Complete the SIU Referral Form and attach to an email and sent to siumanager@usa.g4s.com
  - **Fax** – Complete the SIU Referral Form and Fax;
  - **Phone** – Call the SIU on the toll-free number;
  - **In-Person** – Picked-up by the SIU Regional Representative.

The SIU will maintain a secure Internet Website and 1-800 toll free telephone and fax numbers for the receipt of our client’s surveillance, claim investigation, and SIU assignments. This service is available, at minimum, from 8 a.m. EST to 9 p.m. EST. These numbers are:

**Eastern & Central:**
Voice – [800] 927-0456
Fax – [800] 927-2239

**Western:**
Voice – [888] 501-7017
XII.  **STATE-RELATED NOTICES**

i.  **California Code of Regulations: Fair Claims Settlement Practices Regulations, (Title 10, Chapter 5, Subchapter 7.5, Article 1)**

1. **T. 10 s 2695.5 - Duties upon receipt of communications**

   California - Insurance Regulations

   Duties upon receipt of communications

   (a) Upon receiving any written or oral inquiry from the Department of Insurance concerning a claim, every licensee shall immediately, but in no event more than twenty-one (21) calendar days of receipt of that inquiry, furnish the Department of Insurance with a complete written response based on the facts as then known by the licensee. A complete written response addresses all issues raised by the Department of Insurance in its inquiry and includes copies of any documentation and claim files requested. This section is not intended to permit delay in responding to inquiries by Department personnel conducting a scheduled examination on the insurer’s premises.

   (b) Upon receiving any communication from a claimant, regarding a claim, that reasonably suggests that a response is expected, every licensee shall immediately, but in no event more than fifteen (15) calendar days after receipt of that communication, furnish the claimant with a complete response based on the facts as then known by the licensee. This subsection shall not apply to require communication with a claimant subsequent to receipt by the licensee of a notice of legal action by that claimant.

   (c) The designation specified in subsection 2695.2(c) shall be in writing, signed and dated by the claimant, and shall indicate that the designated person is authorized to handle the claim. All designations shall be transmitted to the insurer and shall be valid from the date of execution until the claim is settled or the designation is revoked. A designation may be revoked by a writing transmitted to the insurer, signed and dated by the claimant, indicating that the designation is to be revoked and the effective date of the revocation.

   (d) Upon receiving notice of claim, every licensee or claims agent shall immediately transmit notice of claim to the insurer.

   (e) Upon receiving notice of claim, every insurer shall immediately, but in no event more than fifteen (15) calendar days later, do the following unless the notice of claim received is a notice of legal action:

   1. acknowledge receipt of such notice to the claimant unless payment is made within that period of time. If the acknowledgement is not in writing, a notation of acknowledgement shall be made in the insurer’s claim file and dated. Failure of an insurance agent or claims agent to promptly transmit notice of claim to the insurer shall be imputed to the insurer except where the subject policy was issued pursuant to the California Automobile Assigned Risk Program.

   2. provide to the claimant necessary forms, instructions, and reasonable assistance, including but not limited to, specifying the information the claimant must provide for proof of claim;

   3. begin any necessary investigation of the claim.

   (f) An insurer may not require that the notice of claim under a policy be provided in writing unless such requirement is specified in the insurance policy or an endorsement thereto.

### Value Added Table

| History | Filed 12-15-92, eff. 1-14-93 (Register 92, No. 52); amd. filed 10-10-97, eff. 11-10-97 (Register 97, No. 2); amd. filed 4-24-2003, eff. 7-23-2003 (Register 2003, No. 17); amd. filed 8-4-2004, eff. 8-4-2004 (Register 2004, No. 33). |
| Cross Reference | Ins s 790.04; Ins s 790.10; Ins s 12340; Ins s 12417; Ins s 12921; Ins s 12926; Gov s 11342.2 |
| Date New | 1992 |
| Date Amended | 1997; 2003; 2004 |
| Due Date | 21 days after |
| Lines of Business | Personal P&C  
Personal Automobile, Personal Credit, Personal Earthquake, Personal Flood, Personal Homeowner Warranty, Personal Homeowners, Personal Inland Marine, Personal Liability, Personal Property, Personal Title, Personal Umbrella/Excess Liability, Personal Vehicle Service Contract, Personal Watercraft  
Commercial P&C  
Life  
Health  
Group Accident, Group Blanket Medical and Disability, Group Comprehensive Major Medical, Group Credit Accident and Health, Group Critical Illness/Specified Disease, Group Dental, Group HMO/Managed Care, Group Industrial Health, Group Long Term Care, Group Long Term Disability, Group Medical/Surgical – Outpatient Benefits, Group Medicare Supplement, Group Short Term Disability, Group Stop Loss, Group Supplemental - Hospital Indemnity, Group Vision, Individual Accident, Individual Comprehensive Major Medical, Individual Credit Accident and Health, Individual Critical Illness/Specified Disease, Individual Dental, Individual HMO/Managed Care, Individual Industrial Health, Individual Long Term Care, Individual Long Term Disability, Individual Medical/Surgical - Outpatient Benefits, Individual Medicare Supplement, Individual Short Term Disability, Individual Supplemental - Hospital Indemnity, Individual Vision |
| Functions | Claims  
General Compliance  
Policy Management  
Product Development |
| Subject Categories | 004 - Duedates  
010 - All/unspecified lines  
020 - Life insurance / insurers  
060 - Health insurance / insurers  
300 - The policy |
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| Information Type | TEXT                      |
2. **CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF INSURANCE...Article 1. Fair Claims Settlement Practices Regulations**

**T. 10 s 2695.7 - Standards for prompt, fair and equitable settlements**

**California - Insurance Regulations**

Standards for prompt, fair and equitable settlements

(a) No insurer shall discriminate in its claims settlement practices based upon the claimant's age, race, gender, income, religion, language, sexual orientation, ancestry, national origin, or physical disability, or upon the territory of the property or person insured.

(b) Upon receiving proof of claim, every insurer, except as specified in subsection 2695.7(b)(4) below, shall immediately, but in no event more than forty (40) calendar days later, accept or deny the claim, in whole or in part. The amounts accepted or denied shall be clearly documented in the claim file unless the claim has been denied in its entirety.

1. Where an insurer denies or rejects a first party claim, in whole or in part, it shall do so in writing and shall provide to the claimant a statement listing all bases for such rejection or denial and the factual and legal bases for each reason given for such rejection or denial which is then within the insurer's knowledge. Where an insurer's denial of a first party claim, in whole or in part, is based on a specific statute, applicable law or policy provision, condition or exclusion, the written denial shall include reference there to and provide an explanation of the application of the statute, applicable law or provision, condition or exclusion to the claim. Every insurer that denies or rejects a third party claim, in whole or in part, or disputes liability or damages shall do so in writing.

2. Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(b)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the subject claim is being investigated as a suspected fraudulent claim.

3. Written notification pursuant to this subsection shall include a statement that, if the claimant believes all or part of the claim has been wrongfully denied or rejected, he or she may have the matter reviewed by the California Department of Insurance, and shall include the address and telephone number of the unit of the Department which reviews claims practices.

4. The time frame in subsection 2695.7(b) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code or mortgage guaranty insurance subject to Section 12840.09(a) of the California Insurance Code, and shall not apply to automobile repair bills arising from policies of automobile collision and comprehensive insurance subject to Section 560 of the California Insurance Code. All other provisions of subsections 2695.7(b)(1), (2), and (3) are applicable.

(c)(1) If more time is required than is allotted in subsection 2695.7(b) to determine whether a claim should be accepted and/or denied in whole or in part, every insurer shall provide the claimant, within the time frame specified in subsection 2695.7(b), with written notice of the need for additional time. This written notice shall specify any additional information the insurer requires in order to make a determination and state any continuing reasons for the insurer's inability to make a determination. Thereafter, the written notice shall be provided every thirty (30) calendar days until the determination is made or notice of legal action is served. If the determination cannot be made until some future event occurs, then the insurer shall comply with this continuing notice requirement by advising the claimant of the situation and providing an estimate as to when the determination can be made.

2. Subject to the provisions of subsection 2695.7(k), nothing contained in subsection 2695.7(c)(1) shall require an insurer to disclose any information that could reasonably be expected to alert a claimant to the fact that the claim is being investigated as a possible suspected fraudulent claim.

(d) Every insurer shall conduct and diligently pursue a thorough, fair and objective investigation and shall not persist in seeking information not reasonably required for or material to the resolution of a claim dispute.

(e) No insurer shall delay or deny settlement of a first party claim on the basis that responsibility for payment should be assumed by others, except as may otherwise be provided by policy provisions, statutes or regulations, including those pertaining to coordination of benefits.

(f) Except where a claim has been settled by payment, every insurer shall provide written notice of any statute of limitation or other time period requirement upon which the insurer may rely to deny a claim. Such notice shall be given to the claimant not less than sixty (60) days prior to the expiration date; except, if notice of claim is first received by the insurer within that sixty days, then notice of the expiration date must be given to the claimant immediately. With respect to a first party claimant in a matter
involving an uninsured motorist, this notice shall be given at least thirty (30) days prior to the expiration date; except, if notice of claim is first received by the insurer within that thirty days, then notice of the expiration date must be given to the claimant immediately. This subsection shall not apply to a claimant represented by counsel on the claim matter.

(g) No insurer shall attempt to settle a claim by making a settlement offer that is unreasonably low. The Commissioner shall consider any admissible evidence offered regarding the following factors in determining whether or not a settlement offer is unreasonably low:

1. The extent to which the insurer considered evidence submitted by the claimant to support the value of the claim;
2. The extent to which the insurer considered legal authority or evidence made known to it or reasonably available;
3. The extent to which the insurer considered the advice of its claims adjuster as to the amount of damages;
4. The extent to which the insurer considered the advice of its counsel that there was a substantial likelihood of recovery in excess of policy limits;
5. The procedures used by the insurer in determining the dollar amount of property damage;
6. The extent to which the insurer considered the probable liability of the insured and the likely jury verdict or other final determination of the matter;
7. Any other credible evidence presented to the Commissioner that demonstrates that any amount offered by the insurer in settlement of a first-party claim to an insured not represented by counsel, or the final amount offered in settlement of a third-party claim by the insurer is below the amount that a reasonable person with knowledge of the facts and circumstances would have offered in settlement of the claim.

(h) Upon acceptance of the claim in whole or in part and, when necessary, upon receipt of a properly executed release, every insurer, except as specified in subsection 2695.7(h)(1) and (2) below, shall immediately, but in no event more than thirty (30) calendar days later, tender payment or otherwise take action to perform its claim obligation. The amount of the claim to be tendered is the amount that has been accepted by the insurer as specified in subsection 2695.7(b). In claims where multiple coverage is involved, and where the payee is known, amounts that have been accepted by the insurer shall be paid immediately, but in no event more than thirty (30) calendar days, if payment would terminate the insurer's known liability under that individual coverage, unless impairment of the insured's interests would result. The time frames specified in this subsection shall not apply where the policy provides for a waiting period after acceptance of claim and before payment of benefits.

1. The time frame specified in subsection 2695.7(h) shall not apply to claims arising from policies of disability insurance subject to Section 10123.13 of the California Insurance Code, disability income insurance subject to Section 10111.2 of the California Insurance Code, or of mortgage guaranty insurance subject to Section 12640.09(a) of the California Insurance Code, and shall not apply to automobile repair bills subject to Section 560 of the California Insurance Code. All other provisions of Section 2695.7(h) are applicable.

2. Any insurer issuing a title insurance policy shall either tender payment pursuant to subsection 2695.7(h) or take action to resolve the problem which gave rise to the claim immediately upon, but in no event more than thirty (30) calendar days after, acceptance of the claim.

(i) No insurer shall inform a claimant that his or her rights may be impaired if a form or release is not completed within a specified time period unless the information is given for the purpose of notifying the claimant of any applicable statute of limitations or policy provision or the time limitation within which claims are required to be brought against state or local entities.

(j) No insurer shall request or require an insured to submit to a polygraph examination unless authorized under the applicable insurance contract and state law.

(k) Subject to the provisions of subsection 2695.7(c), where there is a reasonable basis, supported by specific information available for review by the California Department of Insurance, for the belief that the claimant has submitted or caused to be submitted to an insurer a suspected false or fraudulent claim as specified in California Penal Code Section 550 or California Insurance Code Section 1871.4(a), the number of calendar days specified in subsection 2695.7(b) shall be:

1. Increased to eighty (80) calendar days; or,
2. Suspended until otherwise ordered by the Commissioner, provided the insurer has complied with California Insurance Code Section 1672.4 and the insurer can demonstrate to the Commissioner that it has made a diligent
attempt to determine whether the subject claim is false or fraudulent within the eighty day period specified by subsection 2695.7(k)(1).

(l) No insurer shall deny a claim based upon information obtained in a telephone conversation or personal interview with any source unless the telephone conversation or personal interview is documented in the claim file pursuant to the provisions of Section 2695.3.

(m) No insurer shall make a payment to a provider, pursuant to a policy provision to pay medical benefits, and thereafter seek recovery or set-off from the insured on the basis that the amount was excessive and/or the services were unnecessary, except in the event of a proven false or fraudulent claim, subject to the provisions of Section 10123.145 of the California Insurance Code.

(n) Every insurer requesting a medical examination for the purpose of determining liability under a policy provision shall do so only when the insurer has a good faith belief that such an examination is reasonably necessary.

(o) No insurer shall require that a claimant withdraw, rescind or refrain from submitting any complaint to the California Department of Insurance regarding the handling of a claim or any other matter complained of as a condition precedent to the settlement of any claim.

(p) Every insurer shall provide written notification to a first party claimant as to whether the insurer intends to pursue subrogation of the claim. Where an insurer elects not to pursue subrogation, or discontinues pursuit of subrogation, it shall include in its notification a statement that no recovery to be pursued is the responsibility of the first party claimant. This subsection does not require notification of the deductible unless the claim is paid requires no deductible to be paid, or there is no legal basis for subrogation.

(q) Every insurer that makes a subrogation demand shall include in every demand the first party claimant’s deductible. Every insurer shall share subrogation recoveries on a proportionate basis with the first party claimant, unless the first party claimant has otherwise recovered the whole deductible amount. No insurer shall deduct legal or other expenses from the recovery of the deductible unless the insurer has retained an outside attorney or collection agency to collect that recovery. The deduction may only be for a pro rata share of the allocated loss adjustment expense. This subsection shall not apply when multiple policies have been issued to the insured(s) covering the same loss and the language of these contracts prescribe alternative subrogation rights. Further, this subsection shall not apply to disability and health insurance as defined in California Insurance Code Section 106.


Value Added Table

| History       | Filed 12-15-92, (Register 92, No. 52); amd. filed 1-10-97, (Register 97, No. 2); amd. filed 8-4-2004, (Register 2004, No. 33); amd. filed 9-15-2004, (Register 2004, No. 39); amd. filed 6-1-2006, eff. 8-30-2006 (Register 2006, No. 22). |
| Cross Reference | Ins s 10123.13; Ins s 10111.2; Ins s 12640.09; Ins s 560; Pen s 550; Ins s 1871.4; Ins s 1872.4; Ins s 10123.145; Ins s 106; Ins s 553; Ins s 554; Ins s 790.03; Ins s 790.10; Ins s 1861.03; Ins s 10350.10; Ins s 11580.2; Ins s 12340; Ins s 12417; Ins s 12921; Ins s 12926; Gov s 11342.2 |
| Cited By      | Bulletin 94-10 |
| Date New      | 1992          |
| Date Amended  | 1997, 2004, 2006 |
| Lines of Business | Personal P&C  |
|               | Commercial P&C |

Life


Health

Group Accident, Group Blanket Medical and Disability, Group Comprehensive Major Medical, Group Credit Accident and Health, Group Critical Illness/Specified Disease, Group Dental, Group HMO/Managed Care, Group Industrial Health, Group Long Term Care, Group Long Term Disability, Group Medical/Surgical – Outpatient Benefits, Group Medicare Supplement, Group Short Term Disability, Group Stop Loss, Group Supplemental - Hospital Indemnity, Group Vision, Individual Accident, Individual Comprehensive Major Medical, Individual Credit Accident and Health, Individual Critical Illness/Specified Disease, Individual Dental, Individual HMO/Managed Care, Individual Industrial Health, Individual Long Term Care, Individual Long Term Disability, Individual Medical/Surgical - Outpatient Benefits, Individual Medicare Supplement, Individual Short Term Disability, Individual Supplemental - Hospital Indemnity, Individual Vision

Functions

Claims
General Compliance
Legal
Policy Management
Product Development

Subject

Categories

010 - All/unspecified lines
020 - Life insurance / insurers
060 - Health insurance / insurers
080 - Group insurance (all lines)
140 - Automobile insurance / insurers
200 - Title insurance / insurers
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3. CALIFORNIA CODE OF REGULATIONS...TITLE 10. -- INVESTMENT...Chapter 5. -- Insurance
   Commissioner...Subchapter 7.5 -- UNFAIR OR DECEPTIVE ACTS OR PRACTICES IN THE BUSINESS OF
   INSURANCE...Article 1. Fair Claims Settlement Practices Regulations

T. 10 s 2695.11 - Additional standards applicable to life and disability insurance claims

California - Insurance Regulations

Additional Standards Applicable to Life and Disability Insurance Claims

(a) No insurer shall seek reimbursement of an overpayment or withhold any portion of any benefit payable as a result of a claim on
the basis that the sum withheld or reimbursement sought is an adjustment or correction for an overpayment made under the
same policy unless:

(1) the insurer's files contain clear, documented evidence of an overpayment and written authorization from the
insured or assignee, if applicable, permitting the reimbursement or withholding procedure, or

(2) the insurer's files contain clear, documented evidence pursuant to section 2695.3 of all of the following:

   (A) The overpayment was erroneous under the provisions of the policy.

   (B) The error which resulted in the payment is not a mistake of the law.

   (C) The insurer notifies the insured within six (6) months of the date of the error, except that in instances
of error prompted by representations or nondisclosure of claimants or third parties, the insurer notifies the
insured within fifteen (15) calendar days after the date of discovery of such error. For the purpose of this
subsection, the date of the error shall be the day on which the draft for benefits is issued.

   (D) Such notice states clearly the cause of the error and states the amount of the overpayment.

   (E) The procedure set forth above in (a)(2)(A) through (D) above may not be used if the overpayment is
the subject of a reasonable dispute as to facts.

(b) With each claim payment, the insurer shall provide to the claimant and assignee, if any, an explanation of benefits which shall
include, if applicable, the name of the provider or services covered, dates of service, and a clear explanation of the
computation of benefits.

(c) An insurer may not impose a penalty upon any insured for noncompliance with insurer requirements for precertification of benefits
unless such penalties are specifically and clearly set forth in writing in the policy or certificate of insurance.

(d) An insurer that contests a claim under California Insurance Code Section 10123.13 shall subsequently affirm or deny the claim
within thirty (30) calendar days from the original notification. In the event an insurer requires additional time to affirm or deny
the claim, it shall notify the claimant and assignee in writing. This written notice shall specify any additional information the
insurer requires in order to make a determination and shall state any continuing reasons for the insurer's inability to make a
determination. This notice shall be given within thirty (30) calendar days of the notice (required under Insurance Code Section
10123.13) that the claim is being contested and every thirty (30) calendar days thereafter until a determination is made or legal
action is served. If the determination cannot be made until some future event occurs, the insurer shall comply with this
continuing notice requirement by advising the claimant and assignee of the situation and providing an estimate as to when the
determination can be made.

(e) When a policy requires preauthorization of non-emergency medical services, the preauthorization must be given immediately but
in no event more than five (5) calendar days after the request for preauthorization. The preauthorization shall be
communicated or confirmed in writing to the insured and the medical service provider, and shall explain the scope of the
preauthorization and whether the preauthorization is or is not a guarantee of acceptance of the claim. In the event the
preauthorization is denied, the reason(s) for the denial shall be communicated in writing to the insured and the medical service
provider.

(f) No preauthorization shall be required by an insurer for emergency medical services.

(g) An insurer shall reimburse the insured or medical service provider for reasonable expenses incurred in copying medical records
requested by the insurer.

Authority - §§ 790.10, 12921 and 12926, Insurance Code; and §§ 11342.2 and 11152, Government Code.
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