indigo™
INSURANCE SERVICES

Stop Loss Coverage
Unlimited LTM Disclosure Form

Policyholder Name:_____ Effective Date:_____

The terms of specific stop loss coverage as it pertains to an increase to unlimited life time maximum for the above policyholder is not finalized until Indigo Insurance Services receives, reviews and approves the following information:

List below any member or dependent who has to the best of your knowledge exceeded the previously lifetime maximum under the employer plan

☐ None known

Name or ID number of individual	Category: E=Employee C=COBRA D=Dependent R=Retiree	Date of birth	Sex (M/F)	Diagnosis/ Medical condition	Date exceeded LTM

The information that you provide on this form will be used by us to underwrite the Stop Loss insurance you have applied for with respect to an increase to an unlimited life time maximum. If you fail to disclose a person who you have known to have exceeded the prior life time maximum and submit a claim relating to that person, we will decline this claim as it will be assumed that this person was excluded from the stop loss coverage.
Your signature on this form represents to us that:

You or your duly authorized representative consulted with any prior health plan and/or administrator to identify any member or dependent who would have fallen into this category.

Signature of Authorized Representative of Plan Sponsor:	Print Name:	Title:	Date:
X			

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