indigo™
INSURANCE SERVICES

Instructions for completing Indigo Insurance Services Disclosure Form

1. Determine who needs to be identified as a risk.

You must identify anyone in the following categories:

- Any covered member with claims that have been paid in the past 12 months which are more than 50% of the specific deductible requested for quote;
- Any covered member that is not actively at work due to disability (or other), has been absent from work for 10 consecutive days in the last 12 months, or is working reduced hours due to an illness or injury;
- Any covered member that is currently hospital or institution confined;
- Any covered member that is currently, or is scheduled to be, absent from work due to Family Medical Leave, or Leave of Absence.
- Any covered member currently in case management.

A potential high dollar claimant may also be someone who:

- Is currently receiving total parenteral nutrition (intravenous feeding);
- Is confined to a medical (acute, skilled or rehabilitation) facility or receiving home nursing care for four or more hours per day;
- Is being, or has been, evaluated considered or listed for an organ, tissue, stem cell or bone marrow transplant or has received such a transplant;
- Is using a left ventricular device, ventricular assist device or internal defibrillator;
- Is considered a high-risk pregnancy as determined by precertification;
- Is ventilator dependent;

In addition, a member should be disclosed, if they have not already been identified by Indigo Insurance Services, and they are known to have been treated for any of the following diagnosis within the last 12 months:

Major trauma (eg accident with multiple injuries or internal injuries); amputation; severe burns; head injury; spinal cord injury	Complications of pregnancy, multiple births, premature births, or newborn complications	Mental health or substance abuse disorder that has required an inpatient confinement
Acquired Immune Deficiency Syndrome (AIDS)	Multiple Sclerosis or Nerve Disorder	Congenital Defects
Blood Disorder/Hemophilia	Cerebrovascular Disease or Stroke	Morbid Obesity
Heart/Circulatory Disorder	Liver Disorder	Regional Enteritis
Cancer/Leukemia/Lymphoma	Diabetes	Stomach/Intestinal Disorder
Kidney Disorder (Acute or Chronic)	Epilepsy/Seizures	Bone/Joint/Muscle Disorder
Cystic Fibrosis	Lung/Respiratory Disorder	

This includes all person eligible for benefits under your employee benefit plan, including employees, dependents, retirees and those receiving coverage under COBRA.

2. List any of the individuals falling into the above categories on the disclosure form. You should do this to the best of your knowledge after reviewing:

- Any large claims, pended claims, denied claims, claims on appeal or pre-certed claims documentation from the administrator of your health plan;
- Employee attendance records, sick leave and/or disability reports;

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Stop Loss Coverage Disclosure Form

Policyholder Name:_____ Effective Date:_____

The terms of specific stop loss coverage 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, to the best of your knowledge and based on the criteria on page one of this form, should be identified as a potential large risk.

__ 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

All information disclosed on this statement will be treated as confidential by Indigo Insurance Services. The Policyholder named below, through its authorized officer, hereby requests the information attached is true, complete and accurate. The Policy holder further acknowledges, understands and agrees that this information may be used Indigo Insurance Services in evaluating and determining the acceptability of the risk. The Prospective Policyholder understands and agrees that if any individual is not appropriately disclosed to and approved by Indigo Insurance Services the proposed terms of coverage may be changed or claims relating to that individual may be excluded from Stop Loss coverage. The Prospective Policyholder further acknowledges that if any inaccurate or incomplete information has been willing provided, the proposal for coverage may be withdrawn or coverage may be terminated retroactive to the Effective Date.

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

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