ORIEN
RISK ANALYSTS

EMPLOYER DISCLOSURE STATEMENT

Orien Risk Analysts requires full disclosure on all individuals (including current employees and dependents, COBRA participants and those eligible for COBRA) for which any of the following items would apply. Failure to disclose the information may result in the claimant being excluded under the Stop Loss Agreement. This information should be provided as of a date not to exceed 30 days prior to the proposed effective date:

a. Any employees not actively at work or, in the case of a dependent, not able to perform normal daily activities on the proposed effective date.
b. Any individual that has exceeded 50% of the proposed specific deductible.
c. Any individual that is expected to exceed 50% of the specific deductible.
d. Any individual currently diagnosed with leukemia, Hodgkin's disease, potential organ transplant, burns, cancer, premature birth, chronic renal failure, or chronic hepatitis C.
e. Any individual who has been pre-certified for an inpatient stay or surgical procedure.

1. ACTIVE EMPLOYEES AND THEIR DEPENDENTS.

Name	EE or Dependent	Date of Birth	Date Disabled	Diagnosis	Prognosis Status	Benefits Paid / Pending / Denied Last 12 Months

2. COBRA PARTICIPANTS

Name	EE or Dependent	Date of Birth	Date Disabled	Diagnosis	Prognosis Status	Benefits Paid / Pending / Denied Last 12 Months

The Employer and their Administrator hereby represents that the above list is complete and accurate and that nothing has been knowingly or intentionally omitted. If data has been provided in an attachment of the Employer acknowledges they have been reviewed the reports and all claimants meeting the criteria of this disclosure have been disclosed by initialing this box.

The Employer and his Administrator further acknowledges, understands, and agrees that his information may be used by Orien Risk Analysts in determining the acceptability of risk and that no provisions of the Stop Loss Agreement shall be waived unless specifically agreed to in writing by Orien Risk Analysts. _____

Employer Name: _____

Employer Representative: _____ Date: _____

TPA Representative: _____ Date: _____

This form must be completed, signed by the Employer and his Administrator, and forwarded to Orien within 15 days of the requested effective date in order for coverage to be bound.

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Orien Risk Analysts is a division of Fair American Insurance and Reinsurance Company