IRONSHORE
your safe harbour

IRONSHORE INDEMNITY INC.

P.O. Box 3407
New York, NY 10008
(877) IRON411

APPLICATION FOR STOP LOSS INSURANCE

Application Instructions:

1. Whenever used in this Application, Ironshore Indemnity Inc. shall mean (The Company).
2. Whenever used in this Application, the term "Applicant" shall mean the insured and all subsidiaries.
3. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

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1. Name of Applicant (Plan Sponsor): Madison County Board of Supervisors
   (Full Legal Name)
   Street Address: P.O. Box 608
   City: Canton State: MS Zip: 39046 Telephone:

   Name and Telephone of Primary Contact: Telephone:

   Federal Employer's Tax I.D.#:64-6000658 Number of Years in Business:
   ☐Corporation ☐ Partnership ☐ Proprietorship ☒Other

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2. Insurance/Business Type and Description: County Government SIC Code: 9111

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3. Name and Addresses of Subsidiaries to be covered: NONE

Name:	Type of Business:	Relationship	Address (City, State, Zip)	Number of Employees:

4. Number of Employees at all Locations listed above:
   ☒Actives ☒COBRA ☐ Retirees ☒Disabled

   Single: 218 Family (Employee/Spouse/Children): 140

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5. Name of Administrator: Blue Cross Blue Shield of Mississippi
   Tax I.D. #: 64-0295748
   Street Address: P.O. Box 1043
   City: Jackson State: MS Zip: 39215
6. Proposed Effective Date of Policy: October 1, 2017

   Policy Year Requested:
   From 10-01-2017 to 10-01-2018 both days at 12:01 a.m. at the principal address of the insured.

7. Full Name of Employee Welfare Benefit Plan: Madison County Board of Supervisors Employee Benefit Plan

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A. AGGREGATE STOP LOSS INSURANCE

8. Requested Under the Policy: ☐Yes ☒No

   BENEFITS TO BE INCLUDED:

   ☐ Medical
   ☐ Prescription Drug (Major Med)
   ☐ Prescription Drug Card
   ☐ Vision
   ☐ Weekly Income
   ☐ Other:

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9. Policy Basis / Benefit Period for Aggregate Stop Loss Insurance (check one):
   ☐12/12 ☐15/12 ☐paid ☐12/15 ☐other

   Eligible Expenses Incurred From N/A through N/A; and Eligible Expenses Paid from N/A through N/A.

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10. Aggregate Stop Loss Premium Rates Per Covered Unit:
    N/A Composite

    Annual aggregate premium: N/A

    Monthly Aggregate Accommodation Endorsement: ☐ Included ☐ Not Included

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11. Aggregate monthly factors:
    $ N/A Single/Employee only $ N/A Family (Employee/Spouse/Children)
    $ N/A Composite

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12. Maximum Aggregate Benefit: N/A

    Minimum Annual Aggregate Attachment Point: N/A

    Claim Limit Per Covered Person / Family: $N/A

    Claims Incurred Prior to the Effective Date Are Limited to: N/A

    Benefit percentage payable: N/A

B: SPECIFIC STOP LOSS INSURANCE

13. Requested Under the Policy: ☒Yes ☐No

Benefits To Be Included:
☒ Medical ☒ Prescription Drugs ☒ Prescriptions (Maj Med) ☐ Other:

14. Policy Basis / Benefit Period for Specific Stop Loss Insurance (check one):
☐12/12 ☐15/12 ☐paid ☐12/15 ☒other 24/12

Eligible Expenses Incurred From 10-01-2016 through 09-30-2018; and Eligible Expenses Paid from 10-01-2017 through 09-30-2018.

15. Specific Deductible per covered: ☒Person ☐Family $100,000

Aggregating Specific Deductible: $90,000 ☒Entire Group ☐Named Individuals Only

Maximum Specific Benefit minus the deductible per Covered Person per Policy Year: Unlimited

Claims Incurred Prior To The Effective Date Are Limited To: $N/A

Benefit percentage payable: 100%

16. Separate Individual Specific Deductible and/or individuals named under an Aggregating-Specific Deductible:

17. Specific monthly premium rates:

$27.45 Single/Employee Only $68.63 Family (Employee/Spouse/Children)

Annual Specific premium: N/A

18. Additional options requested and included in premiums stated above:

☐	Organ transplant carved out	☐	Specific Transplant Step-Down Deductible
☐	ASO Specific Terminal Liability Option $	☐	Specific Transplant Critical Care
☐	Aggregate Terminal Liability Option $	☐	Family Specific Deductible
☐	Other.....	☐	None

19. Special Limitations:
Specific: NONE
Aggregate: NONE

20. An initial premium deposit of N/A is enclosed to apply to the first payment under the Policy, if issued, subject to the requirements below. If the application is not accepted, the deposit will be returned.

It is understood and agreed that as a condition precedent to the approval of the Application that:

A. THE APPLICANT AGREES AND ACKNOWLEDGES THAT, DEPENDING UPON THE COVERAGE SELECTED AND THE TERMS OF ANY EXPIRING COVERAGE OR COVERAGE THE APPLICANT MAY ELECT IN THE FUTURE, THE APPLICANT MAY EXPERIENCE LOSSES THAT ARE NOT COVERED UNDER THE POLICY, WHEN ISSUED, OR UNDER ANY SUCH PRIOR OR SUBSEQUENT COVERAGE.

B. Any Stop Loss Insurance resulting from this Application shall be described in and shall be subject to the terms and provisions of the Policy, when issued. Such Policy shall become effective on the date specified in this Application; provided that, including, without limitation: (1) a true and correct Disclosure Statement has been received, (2) the underwriting requirements have been satisfied, (3) the required premiums have been paid, (4) a copy of the executed Plan Document is received and acceptable to the Company pursuant to paragraph C. below, and (5) the Policy has been issued.

C. Within ninety (90) days from the date of this Application, the Applicant shall furnish to Ironshore Indemnity Inc. (the Company), for its approval, a copy of the executed employee benefit plan (the Plan) describing the benefits provided by the Plan. The Plan shall be kept on file in the office of the Company. No Policy will be released nor claim reimbursed until such time as an acceptable Plan is received and accepted by the Company. If a copy of the Plan is not received by the Company within ninety (90) days from the date of this application, all premium will be refunded and coverage will be automatically null and void retroactive to the proposed effective date. If in the sole judgment of the Company there is a material variance between the provisions of the Plan received by the Company, and the Plan provision upon which the terms and rates of the aggregate and specific excess coverage were based, the Company may, at its option, notify the Applicant of such variances and decline to release the Policy until such time as an amended Plan is received and accepted and, in the event such amended Plan is not received and accepted by the Company within thirty (30) days of such notice, all premium will be refunded and coverage will automatically be null and void retroactive to the proposed effective date.

D. The Applicant will provide or employ supervision and claim administration facilities acceptable to the Company to administer the Plan and to process and pay claims according to the Plan.

E. The receipt by the Company of the initial premium deposit listed in item number 20 of this Application and the deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event that the Company does not approve this Application, its sole obligation shall be to refund the deposit to the Applicant.

F. The Applicant represents that the statements and declarations made in this Application, the Disclosure Statement, and in the Plan referred to in this Application are true and complete and the Policy, when issued, will be issued in reliance upon the truth and completeness of such statements and declarations. The Disclosure Statement, this Application and the Plan shall form a part of the Policy, and the Policy shall constitute all agreements existing between the Applicant and the Company, or any of their respective agents, relating to this Stop Loss Insurance for which this application is being made.

G. 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, may be guilty of insurance fraud.

The Applicant represents that it, directly or through its authorized agent, has read this Application in its entirety and has been given the opportunity to ask any questions it may have. The Applicant further understands that the insurance required does not start unless this Application is approved and accepted by the Company.

Date: _____
Applicant's Executive Officer (print): _____
Title: _____
Signature: _____

Date: _____
Insurance Agency: _____
Insurance Agency Taxpayer ID or SSN: _____

Licensed Agent's Name (print): _____
Title: _____
Agent License No. _____

Signature: _____

ACCEPTED BY THE COMPANY:

Date: _____

By: _____

Title: _____