AGENDA ITEM or FINAL CONTRACT REVIEW SUBMITTAL FORM

Agenda Item: Stop Loss 2019 Renewal - IOA

Action Requested: County Manager Signature

Parties to the Agreement: Companion Life Insurance Company (IOA Re-Stop Loss) & Gunnison County, Colorado

Term Begins: **Term Ends:** **Grant Contract #:**

Summary:

Application made to Companion Life Insurance Company for Excess Loss Insurance for the County's Employee Benefit Plan

Fiscal Impact: Rate increase for 2019 Stop Loss Insurance

Submitted by: Cheryl Seling **Submitter's Email Address:** cseling@gunnisoncouny.org

Finance Review: (●) Required ( ) Not Required

Comments:

Fixed cost increase is 10% for specific premium (total of $32,235 more in 2019 than in 2018); and 31% for aggregate premium ($3,295 more in 2019 than in 2018). Estimated maximum plan year cost is 16.94% more than 2018, total of $314,000 and includes fixed costs and expected claims cost. These totals are included in the 2019 proposed budget. No concerns. ln

Reviewed by: GUNCOUNTY1\lNienhueser Discharge Date: 12/11/2018

County Attorney Review: (●) Required ( ) Not Required

Comments:

ok db 12/12/18

Reveiwed by: GUNCOUNTY1\dBaumgarten Discharge Date: 12/12/2018 Certificate of Insurance Required Yes ( ) No (●)

County Manager Review:

Comments:

Reveiwed by: GUNCOUNTY1\mbirnie Discharge Date: 12/12/2018

(●) Consent Agenda ( ) Regular Agenda ( ) Worksession Time Allotted: 0

Agenda Date: 12/18/2018

Revised April 2015

APPLICATION TO
COMPANION LIFE INSURANCE COMPANY
COLUMBIA, SC 29223
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

Application is hereby made to the Companion Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant: Gunnison County

2. Address: 200 E. Virginia Avenue

   City: Gunnison State: CO Zip Code: 81230

3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.

   None

4. Enter the full name of your Employee Benefit Plan(s).
   (A copy of such Employee Benefit Plan(s) must be attached.)

   Gunnison County - Employee Benefit Plan

5. Name and address of Designated Third Party Administrator:

   CoreSource, 35601 Mound Road, Sterling Heights, MI 48310

6. Effective Date: January 1, 2019 to January 1, 2020

7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):

   73 Singles; 28 Employee + Spouse; 11 Employee + Child(ren); 31 Family

8. **GENERAL SCHEDULE OPTIONS:**

   (a) Disabled Persons [X] are covered, provided such persons have been disclosed to, and accepted by, the Company.
   [ ] are not covered.

   Retired Employees [ ] are [X] are not covered.

   (b) Aggregate Benefit [X] Yes [ ] No

   Aggregate Contract Basis: Employee Benefit Plan Expenses must be
   Incurred from 1/1/18 to 1/1/20, and
   Paid from 1/1/19 to 1/1/20.

   Claims Incurred prior to the Contract Effective Date are limited to $N/A.

Applicant Initials _____

8. **GENERAL SCHEDULE OPTIONS**: (Continued)

Aggregate Eligible Expenses include:
[X] Medical
[ ] Dental Care
[ ] Vision Care
[X] Prescription Card Service
[ ] Weekly (Disability) Income
[ ] Other

Aggregate Monthly Factor per Single Employee:	$ 579.34
Employee + Spouse:	$ 1,154.05
Employee + Child(ren):	$ 1,021.38
Family:	$ 1,733.39

Aggregate Payable Percentage (excess of Deductible):	100%
Maximum Eligible Claim Expense Per Covered Person:	$ 50,000
Minimum Aggregate Deductible:	$1,674,906
Maximum Aggregate Benefit (excess of Deductible):	$1,000,000

(c) Monthly Aggregate Accommodation: [ ] Yes [X] No

(d) Aggregate Terminal Liability: [ ] Yes [X] No

(e) Specific Benefit [X] Yes [ ] No - See Addendum No. 1

Specific Contract Basis: Employee Benefit Plan expenses must be
Incurred from 1/1/18 to 1/1/20
Paid from 1/1/19 to 1/1/20.
Claims Incurred Per Covered Person prior to the Contract Effective Date are limited to: $ N/A

Specific Eligible Expense include:
[X] Medical
[ ] Prescription Drug under Medical
[X] Prescription Card Service
[ ] Other

Specific Deductible (per person):	$ 50,000
Specific Payable Percentage (excess of Deductible):	100%
Maximum Specific Benefit (per person in excess of Specific Deductible):	$ Unlimited

(f) Simultaneous Specific Reimbursement: [X] Yes [ ] No

(g) Aggregating Specific Deductible: $40,000 [X] Yes [ ] No

(h) Specific Terminal Liability: [ ] Yes [X] No

9. **PREMIUMS:**

(a) Aggregate Premium
Premium Per Month Per Unit: $ 8.13

Monthly Aggregate Accommodation
Premium Per Month Per Unit: $ N/A

(b) Specific Premium
Premium Per Month Per

Single Employee:	$ 125.58
Employee + Spouse:	$ 244.68
Employee + Child(ren):	$ 217.19
Family:	$ 364.75

10. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

(a) All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within ninety (90) days of the requested Effective Date.

(b) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:

(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or

(2) if a dependent or Continuation Beneficiary, he or she is able to perform the normal functions of a person of like sex and age.

(c) Issuance of the Contract is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of the Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

(d) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(e) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Companion Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(f) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(g) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Contract Period.

(h) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.

(I) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(j) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

Applicant Initials _____

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Dated at Gunnison CO this 10th day of December 2018

Witness: [signature] Applicant: Gunnison County
Signature of Licensed Agent

Tax ID #: _____

By: _____
(Officer/Partner)

Title: _____

Licensed Agent: Frank M. Stichter
(Type or Print)

Address: 427 Belleview Ave Suite 203 POB 164

City: Crested Butte State: CO Zip: 81224

ACCEPTANCE

Accepted on behalf of the Company, this _____ day of _____

By: _____

Title: Executive Vice President

Contract No.: IOARE-1084-191 Effective Date: January 1, 2019

Addendum No 1 to
APPLICATION FOR EXCESS LOSS INSURANCE

It is hereby understood and agreed that this Addendum forms a part of the Application for the Contract of Excess Loss Insurance issued by Companion Life Insurance Company to Gunnison County (herein called the Applicant), with a Contract Period of January 1, 2019 to January 1, 2020 (herein called the Contract).

It is further agreed that:

1. The Specific Deductible (per person) for said Contract Period for Kari Allen, Date of Birth 05/16/1986, dependent spouse, of employee Anthony Allen, shall be $95,000.

2. The Specific Deductible (per person) for said Contract Period for employee Joni Reynolds, Date of Birth 07/20/1950, shall be $95,000.

As part of the Application for the Contract, this Addendum modifies or confirms the terms and conditions of the coverage provided by the Contract to the extent stated herein.

Signed for the Applicant by_____
Authorized Signature

Title_____

Date_____