



UPSHUR COUNTY COMMISSIONERS COURT

BILMER, TEXAS

5-3-91

Commissioners Court met in emergency session with all members present.

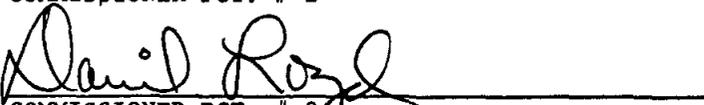
Tom Slack met with the court to discuss the insurance proposals that were submitted. He outlined the funding for the insurance program for the officials who have been elected since the program was set up. All the proposals were compared and discussed. Proposals were from: Anthem, Standard, Transport, Safeco, Lloyds London, American Heritage and Mutual Benefit. Copies of proposals considered are attached and all will be on file in the County Clerk's Office.

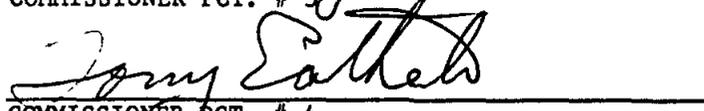
Motion by Tommy Eatherton seconded by David Loyd to adjourn. Motion carried.


COUNTY JUDGE


COMMISSIONER PCT. # 1


COMMISSIONER PCT. # 2


COMMISSIONER PCT. # 3


COMMISSIONER PCT. # 4



RISK FUNDING
ALTERNATIVES, INC.

April 25, 1991

Mr. Vernon Vick
County of Upshur
P. O. Box 730
Gilmer, Texas 75644

Dear Mr. Vick:

We are at this time providing the attached detail on our Third Party Administrator services, a background sketch of each of the Risk Funding Alternatives, Inc. principals, company history and concept, system capabilities, reporting flexibility and membership and claims adjudication services.

Our TPA services will include all administration (as well as COBRA administration). This proposal for complete administration will be priced at \$9.50 per employee per month (plus 2% of billed COBRA premium). The enclosed stop loss proposal is based on using Intracorp as your utilization review service. An Intracorp proposal has been included with the TPA proposal.

Our organization stands at your disposal during this period of time as concerns on site visits and review of system capabilities, etc. Our concept is totally service oriented and geared to the individual needs of our clientele. Please let me know how I can be of assistance.

Sincerely,

Tom W. Slack, Jr.
President

TWS/kb

Encl.

The rates below shall include coverages or exclusions as specified in the current benefit specifications.

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (61)	<u>\$38.37</u>
Emp/Dep. (70)	<u>\$71.73</u>
Estimated Annual	<u>\$88,340.00</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month	<u>\$5.34</u>
Monthly Aggregate Cap	Not available
Estimated Annual	<u>\$8,394.00</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (131)	<u>\$319.08</u> (composite)
Employee/Dependent	
Total Annual	<u>\$501,594.00</u>

<u>TERM LIFE PLAN</u>	
Volume: <u>\$2,000,500</u>	
Term: <u>\$.54 / \$1,000</u>	
AD&D: <u>\$.06 / \$1,000</u>	
Estimated Annual	<u>\$14,400.00</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company Mutual Benefit Life/Health
Phoenix Mutual/Life

VOL 37 PG 124

-02-0660-0022-05 MUTUAL BENEFIT LIFE
04/07/91 11:17 AM

SCHEDULE -- Excess Medical Insurance

NAMED INSURED: UPSHUR COUNTY
ADDRESS: P.O. BOX 730
CITY GILMER STATE TX ZIP CODE 75644

PROPOSED DATE: 04/07/91
EFFECTIVE DATE: 06/01/91
EXPIRATION DATE: 06/01/92

Coverage is only applicable to the category for which a retention amount is shown and such retention amount is applicable only to the Policy Year. If the insurance is continued beyond the Expiration Date stated above, the retention amounts for subsequent Policy Years will be determined annually by the Company. If no retention amount is shown, coverage is not provided for that category.

(A) SPECIFIC EXCESS INSURANCE

(1) Specific Retention Amount
per (X) Covered Person for the Policy Year \$ 25,000
() Family -----

(2) Company's Limit of Liability (reimbursement Factor)
100% of payments in excess of the Specific Retention Amount
Specific Annual Maximum Amount per Covered Person \$ 975,000

(3) Premium Rates Payable for the Policy Year (X) Monthly;
() Annually.
Covered Unit Renewal Protection
Rider INITIAL

(X) Single Employee \$ 38.37 \$ 44.12 -----
(X) Family \$ 71.73 \$ 82.48 -----

RENEWAL PROTECTION RIDER AVAILABLE FOR ADDITIONAL 15%. MUST INITIAL IF PURCHASED

(B) AGGREGATE EXCESS INSURANCE

(1) Monthly Aggregate Retention Amount Factor: S 319.08
F composite

(2) Number of Initial Covered Units: S 61
F 70

(3) Minimum Annual Aggregate Retention Amount: \$ 426,355
(85% of aggregate attachment point) -----

(4) Company's Limit of Liability (Reimbursement Factor)
100% of payments in excess of the Annual Aggregate Retention Amount to a maximum of \$ 1,000,000.

(5) Premium Rates Payable for the Policy Year (X) Monthly;
() Annually. composite \$ 5.34

(C) ADMINISTRATORS OF BENEFIT PLAN: RISK FUNDING ALTERNATIVES
P.O. BOX 130187
TYLER TX 75713

The attached Application and Qualification of the Offer are an integral part of this quotation.

c/o STOP LOSS INTERNATIONAL CORPORATION,
Indianapolis, Indiana 46268

3333 Founders Road
(317) 876-0399

-02-0660-0022-05 MUTUAL BENEFIT LIFE
04/07/91 11:17 AM

c/o STOP LOSS INTERNATIONAL CORPORATION,
Indianapolis, Indiana 46268

3333 Founders Road
(317) 876-0399

EXCESS LOSS INSURANCE
APPLICATION

Application is made for a policy providing the insurance specified below.

1. Name of Applicant UPSHUR COUNTY
Address P.O. BOX 730 GILMER TX Zip Code 75644
(where policy is to be delivered)
2. Administrators of Benefit Plan RISK FUNDING ALTERNATIVES
Address P.O. BOX 130187 TYLER TX Zip Code 75713
3. Benefits to be covered under the Aggregate Excess Loss Insurance are:
 Medical Insurance Dental Weekly Income
 Vision Prescription Drugs
4. Aggregate Excess Loss Insurance
100% of paid claims for covered expenses in excess of the Aggregate Deductible Amount to be reimbursed by Company.
5. Proposed effective date 06/01/91 (subject to Home Office acceptance)
6. Deposit of \$8,061.21 is enclosed to apply on the first payment under the policy as issued.

	Under Age 65	TEFRA & COBRA
Number of Employees:	131	0
Expected Paid Claims:	\$ 255.26 EE/MO	\$ 255.26 EE/MO
Aggregate Expected Claims:	\$ 401,269	\$
Attachment Point:	\$ 319.08 EE/MO	\$ 319.08 EE/MO
Aggregate Attachment Point:	\$ 501,594	\$
Specific Coverage:	\$ 975,000 x/s	\$ 975,000 x/s
	\$ 25,000	\$ 25,000

Signed at _____

Date _____

Applicant (correct legal name)

By (officer's name and title)

Applicant's Agent of Record

The attached Qualification of the Offer is an integral part of this quotation.

VOL 37 PG 176

-02-0660-0022-05 MUTUAL BENEFIT LIFE

04/07/91 11:17 AM

Qualification of the Offer

Page 3 of 5

APPLICANT: UPSHUR COUNTY

The premium and maximum employer plan liability are based on the data submitted, plus other information furnished relevant to underwriting the risk, including statistics with reference to premiums paid and claims incurred with the present carrier. Any inaccuracy in the data or statistics submitted will necessitate additional calculations.

For illustrative purposes, the cost comparisons used the same rates, exposure, benefits, dividend formula and other assumptions throughout. Variations will, of course, affect results.

Subject to the qualifications stated above, the proposal is valid for an effective date of 06/01/91, provided you submit an application and deposit premium before 06/01/91.

IT IS EXPRESSLY AGREED THAT THE INSURANCE BROKER AND/OR TPA ARRANGING FOR YOUR APPLICATION IS YOUR AUTHORIZED AGENT AND IS FOR NO PURPOSE THE LEGAL AGENT OF THE MANAGING UNDERWRITER, STOP LOSS INTERNATIONAL CORPORATION, OR FOR THE INSURER EXCEPT AS REQUIRED FOR LICENSING, AND YOU HEREBY APPOINT BROKER AND/OR TPA AS YOUR AUTHORIZED AGENT FOR ALL PURPOSES CONCERNING THE INSURANCE APPLIED FOR HEREUNDER. YOU, THE APPLICANT, ARE NOT ENTITLED TO RELY UPON THE ORAL OR WRITTEN REPRESENTATIONS OF THE BROKER OR TPA AS BINDING UPON MANAGING UNDERWRITER OR INSURER.

SPECIFIC COVERAGE:

* Specific quote is on an incurred and paid basis.

AGGREGATE COVERAGE:

* Aggregate quote is on an incurred and paid basis.

The attached Schedule and Application are an integral part of this quotation.

c/o Stop Loss International,
Indianapolis, Indiana 46268

3333 Founders Road
(317) 876-0399

-02-0660-0022-05 MUTUAL BENEFIT LIFE
04/07/91 11:17 AM Qualification of the Offer

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Page 4 of 5

APPLICANT: UPSHUR COUNTY

OTHER REQUIREMENTS:

- * Quote is invalid unless producing agent holds a current, valid life and A & H license.
- * Quote is subject to adjustment based upon claims paid through 04/30/91.
- * Quote is tentative based upon claims documentation.
- * Quote is tentative pending receipt and approval of all claims in excess of \$ 12500.00 for the period 06/01/90 through 05/31/91.
- * Actively at work provisions apply.
- * Maximum of \$ 25000.00 applies for the treatment of Mental and Nervous disorders and for Drug and Alcohol treatment.
- * Continuation of current benefits applies.
- * Expenses resulting from loss or damage directly or indirectly occasioned by, happening through, or in consequence of war, invasion, acts of foreign enemies, hostilities, civil war (whether war be declared or not), rebellion, revolution, insurrection, military or usurped power or confiscation or nationalization or requisition or destruction of or damage to property by or under the order of any government or public or local authority are not reimbursable expenses under this contract.
- * REQUIRE CONFIRMATION THAT CLAIMANTS SHOWING NO LONGER ON GROUP HAVE NOT ELECTED COBRA; SPECIFIC TERMS ARE SUBJECT TO ADJUSTMENT AFTER REVIEW OF APS ON \$11,893 RETIRED SPOUSE OF EE W/BRONCHITIS & EMPHYSEMA, HIGHER SIR WILL APPLY IF APS NOT REC'D BY 6/30/91 &/OR UNFAVORABLE. SCH/A/DS

The attached Schedule and Application are an integral part of this quotation.

c/o STOP LOSS INTERNATIONAL CORPORATION,
Indianapolis, Indiana 46268

3333 Founders Road
(317) 876-0399

08-1991 10:03 FROM

STOP LOSS INSURANCE

TO 9-1-9035342854---85

P.01

VOL 37 PG 178

TO 9-1-9035342854---85

P.02

-02-0660-0022-05 MUTUAL BENEFIT LIFE
04/07/91 11:17 AM Optional Coverage

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APPLICANT: UPSHUR COUNTY

OTHER REQUIREMENTS:

* Conversion Benefit Yes No
\$.60 per employee per month. Benefit may be available to
Associations subject to 60 day prior approval by Celtic Life
at a rate of \$.85 per employee per month. Conversion not
available to Multiple Employer Trusts.

The attached Schedule and Application are an integral part of this quotation.

/o STOP LOSS INTERNATIONAL CORPORATION,
Indianapolis, Indiana 46268

3333 Founders Road
(317) 876-0399

The rates below shall include coverages or exclusions as specified in the current benefit specifications.

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (57)	<u>\$28.79 37.53</u>
Emp/Dependent (63)	<u>\$66.93 49.51</u>
Estimated Annual	<u>\$70,291.44</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month	<u>\$5.76</u>
Monthly Aggregate Cap	not available
Estimated Annual	<u>\$8,294.40</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (120)	<u>\$390.95 (composite)</u>
Employee/Dependent	
Total Annual	<u>\$575,928.00</u>

<u>TERM LIFE PLAN</u>	
Volume:	<u>\$1,962,500</u>
Term:	<u>\$.83/\$1,000</u>
AD&D:	<u>\$.06/\$1,000</u>
Estimated Annual	<u>\$20,959.44</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company American Heritage/health
Lafayette Life/life

BENEFIT PLAN #2

The rates below shall include ALL of the benefits outlined in the current plan with ONLY the following changes:

- Increase deductible to \$500, and
- Delete Prescription Drug Card

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (57)	<u>\$28.79</u>
Emp/Dependent (63)	<u>\$66.93</u>
Estimated Annual	<u>\$70,291.44</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month	<u>\$5.34</u>
Monthly Aggregate Cap	not available
Estimated Annual	<u>\$7,689.00</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (120)	<u>\$311.15 (composite)</u>
Employee/Dependent	<u> </u>
Total Annual	<u>\$448,056.00</u>

<u>TERM LIFE PLAN</u>	
Volume:	<u>\$1,962,500</u>
Term:	<u>\$.83 /\$1,000</u>
AD&D:	<u>\$.06 /\$1,000</u>
Estimated Annual	<u>\$20,959.44</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company American Heritage Life Ins. Co./health
Lafayette Life Insurance Co./life

The rates below shall include ALL of the benefits outlined in the current plan with ONLY the following changes:

Increase deductible to \$500,
Delete Prescription Drug Card, and
Increase Stop Loss to 80% to \$10,000

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (57)	<u>\$28.79</u>
Emp/Dependent (63)	<u>\$66.93</u>
Estimated Annual	<u>\$70,291.44</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month	<u>\$5.34</u>
Monthly Aggregate Cap	not available
Estimated Annual	<u>\$7,689.60</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (120)	<u>\$302.81</u> (composite)
Employee/Dependent	
Total Annual	<u>\$436,046.40</u>

<u>TERM LIFE PLAN</u>	
Volume: <u>\$1,962,500</u>	
Term: <u>\$.83 /\$1,000</u>	
AD&D: <u>\$.06 /\$1,000</u>	
Estimated Annual	<u>\$20,959.44</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company American Heritage Life Ins. Co./health
Lafayette Life Insurance Co./life

14898 S.H. 16 North
P.O. Box 1191
HELOTES, TEXAS 78023-1191
(512) 695-2381
FAX: (512) 695-2387

VOL 37 PG 182

TO: RISK FUNDING ALTERNATIVES

ATTN: SUE BRATMAN

ACCOUNT UPSHUR COUNTY

ENROLLMENT SINGLE- 57 FAMILY- 63 TOTAL- 120

LOSS FUND \$500,846.40 (med., dental, & prescription drug card)

LOSS FUND FACTORS

COMP-\$347.81

AGGREGATE PREMIUM \$5.76/EE./MO.

AGGREGATE POLICY PAID W/A 90 DAY RUN-IN LIMITED TO \$66,000

SPECIFIC DEDUCTIBLE \$25,000 12/12 \$25,000 15/12 \$35,000 12/12 \$35,000 15/12

RATES SINGLE \$28.79 \$37.53 \$21.50 \$28.63

FAMILY \$66.93 \$87.04 \$50.47 \$66.86

SPECIFIC PREMIUM \$70,291.44 \$91,472.76 \$52,801.32 \$70,129.08

SPECIFIC POLICY 12/12 OPTION 15/12 LIFETIME MAX: \$1,000,000 less the spec. ded.

UNDERWRITERS - EXCESS STOP LOSS AMERICAN HERITAGE LIFE INS. CO.

GROUP LIFE/AD&D FAYETTE LIFE INS. CO.

LIFE/AD&D - VOLUME \$1,962,500 NUMBER OF LIVES 120

RATES - LIFE \$.83 AD&D \$.06 /\$1,000

BENEFITS Age Reduction - Reduces 50% at age 70, another 50% at age 75 and terminates at retirement.

EXPIRATION DATE JUNE 1, 1991

NOTES Actively at work provision prevails. No current disabilities will be covered without prior written approval. All rates include 10% level commissions. Quotation is based on verification of claims data, number of employees enrolled and experience information. Should any of this vary, quotation is subject to recalculation.

Rebecca Gaudin
4424191

The rates below shall include coverages or exclusions as specified in the current benefit specifications.

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (46)	<u>\$33.50</u>
Emp/Dep. (76)	<u>\$83.75</u>
Estimated Annual	<u>\$94,872.00</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month (122)	<u>\$5.10</u>
Monthly Aggregate Cap	<u> </u>
Estimated Annual	<u>\$7,466.00</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (122)	<u>\$321.83 (composite)</u>
Employee/Dependent	<u> </u>
Total Annual	<u>\$471,159.00</u>

<u>TERM LIFE PLAN</u>	
Volume: <u>\$2,000,500</u>	
Term: <u>\$.54/\$1,000</u>	
AD&D: <u>\$.06/\$1,000</u>	
Estimated Annual	<u>\$14,400.00</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company Lloyd's London/Health
Phoenix Mutual/Life

The rates below shall include ALL of the benefits outlined in the current plan with ONLY the following changes:

Increase deductible to \$500, and
Delete Prescription Drug Card

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (46)	<u>\$33.50</u>
Emp/Dependent (76)	<u>\$83.75</u>
Estimated Annual	<u>\$94,872.00</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month (122)	<u>\$4.71</u>
Monthly Aggregate Cap	<u> </u>
Estimated Annual	<u>\$6,895.44</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (122)	<u>\$280.92 (composite)</u>
Employee/Dependent	<u> </u>
Total Annual	<u>\$411,267.00</u>

<u>TERM LIFE PLAN</u>	
Volume: <u>\$2,000,500</u>	
Term: <u>\$.54</u> / \$1,000	
AD&D: <u>\$.06</u> / \$1,000	
Estimated Annual	<u>\$14,400.00</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company Lloyd's London/Health
Phoenix Mutual/Life

The rates below shall include ALL of the benefits outlined in the current plan with ONLY the following changes:

Increase deductible to \$500,
Delete Prescription Drug Card, and
Increase Stop Loss to 80% to \$10,000

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

SPECIFIC STOP LOSS \$25,000

Employee (46)	<u>\$33.50</u>
Emp/Dependent (76)	<u>\$83.75</u>
Estimated Annual	<u>\$94,872.00</u>

AGGREGATE STOP LOSS

Per Employee Per Month (122)	<u>\$4.71</u>
Monthly Aggregate Cap	
Estimated Annual	<u>\$6,895.44</u>

MAXIMUM AGGREGATE CLAIMS FUND

Employee (122)	<u>\$275.81</u> (composite)
Employee/Dependent	
Total Annual	<u>\$403,785.84</u>

TERM LIFE PLAN

Volume:	<u>\$2,000,500</u>
Term:	<u>\$.54 /\$1,000</u>
AD&D:	<u>\$.06 /\$1,000</u>
Estimated Annual	<u>\$14,400.00</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company Lloyd's London/Health
Phoenix Mutual/Life

COX INSURANCE GROUP, INC.



RAY COX - PRESIDENT

TEL: 317/887-0090
 TELEX 276252
 FACSIMILE: 317/888-7145

Lloyd's London Correspondent

570 COMMERCE CIRCLE
 P.O. BOX 1708
 INDIANAPOLIS, IN 46217-0008

AGGREGATE AND/OR SPECIFIC STOP LOSS PROPOSAL

SECTION I: GENERAL

- 1) Prospective Insured : UPSHUR COUNTY
- 2) Address (headquarters): Gilmer, TX 75644
- 3) Other Locations :
- 4) Proposal Presented to : RISK FUNDING ALTERNATIVES, INC/TX

(CASE NO. 6781)

SECTION II: CONDITIONS AND ASSUMPTIONS

- 1) Assumed Effective Date: 06-01-91 Proposal Expiration Date: 06-01-91.
- 2) Unless otherwise indicated, terms are based on current benefits.
- 3) Insured will provide or employ plan supervision and claims administration facilities acceptable to Lloyd's London.
- 4) Insured will provide Plan Document acceptable to Lloyd's Underwriters within 90 days of effective date.
- 5) This is a TENTATIVE Proposal based on information furnished in your request. The Proposal will be firm upon receipt/approval of documentation of experience and approval of the risk by Lloyd's Underwriters.
- 6) For groups located in Indiana, it is the responsibility of Cox Insurance Group (CIG) to make the appropriate surplus lines filings. Surplus lines taxes should be remitted in addition to the Lloyd's premium.
- 7) For groups located in states other than Indiana, Kentucky, or Illinois, it is the responsibility of the Plan's agent or consultant (NOT CIG) to collect and see to the timely payment of any applicable excess/surplus lines taxes and to otherwise assure compliance with all such requirements in the state in which the Insured is situate. CIG will be happy to refer the producer to a surplus lines agent/broker in these states if requested to do so.
- 8) Lloyd's is an admitted insurer in Illinois and Kentucky and is therefore responsible for paying premium tax in those states. For groups located in Illinois and Kentucky, there is a service charge per stop loss contract which should be remitted in addition to the Lloyd's premium. The amount of the service charge varies according to the premium (see Sections IV and V).
- 9) Annual projections are subject to revision based on the enrollment at inception.
- 10) The Lloyd's coverage contains a Pre-Existing Conditions Exclusions Clause applicable to new enrollees.

SECTION III: DEFINITIONS

- 1) **INCURRED and PAID CONTRACT:** Under this type of contract, Underwriters shall only be liable for reimbursement of those eligible claims actually INCURRED and PAID by the Plan during the Period of Insurance. Neither expenses accrued prior to the Period of Insurance, nor those actually paid after the Period of Insurance are eligible for reimbursement by Underwriters.
- 2) **PAID CONTRACT:** Under this type of contract, Underwriters shall only be liable for reimbursement of those eligible claims PAID by the plan during the Period of Insurance ("PAID" is defined below).
- 3) **INCURRED CONTRACT:** Under this type of contract, Underwriters shall only be liable for reimbursement of the eligible claims INCURRED by the Plan during the Period of Insurance ("INCURRED" is defined below). All expenses INCURRED during the Period of Insurance must be PAID during the Period of Insurance or during the THREE (3) months immediately following the Period of Insurance ("PAID" is defined below).
- 4) **INCURRED:** The word "incurred" means, as respects a claim under a benefit plan covered by the contract, that a service has been performed, a purchase has been made, or a person has earned periodic payment because of total disability.
- 5) **PAID:** Payment of a claim shall be deemed to occur on the date when the Insured's (or his legally contracted agent for such purpose) payment check or draft is issued, provided that it is promptly thereafter delivered to the payee and is paid upon presentation.

Lloyd's London Correspondent

UPSHUR COUNTY

SECTION IV: AGGREGATE

Employees by benefit:	MEDICAL			
Single/Attachment Factor:	46/321.83			
Family/Attachment Factor:	76/321.83			
Total employees:	122			
Premium per ee per month:	5.10			

Minimum Attachment Point: \$471,159.12 5) Maximum Indemnity: \$1,000,000

Type of Contract: Paid Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91 which are paid during the Period of Insurance. Claims incurred prior to 06-01-91 are limited to \$33,000

Estimated Annual Premium: \$7,466.40 Deposit Premium: \$522.20 Minimum Premium: \$3,200

Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)

Specific is required with purchase of Aggregate

SECTION V: SPECIFIC

DEDUCTIBLE	SINGLE/RATE	FAMILY/RATE	DEPOSIT PREMIUM	EST ANNUAL PREMIUM	MINIMUM PREMIUM
25,000	46/33.50	76/83.75	7,906.00	94,872.00	66,400

Coinurance by insured: 0% excess of Deductible.

Maximum Indemnity: \$1,000,000 Maximum Aggregate Indemnity for all Specific Excess Claims combined during the Period of Insurance: \$2,000,000

Type of Contract: Paid (Annual Deductible per person, ALL cause) Paid Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91

Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)

SECTION VI: ADDITIONAL REQUIREMENTS

This tentative proposal is subject to revision pending our receipt of the following:

SEE ATTACHED

SECTION VII: NOTES

we assume continuation of current benefit schedule. This proposal replaces and voids all others issued from this office regarding Upshur County or to this date.

Date: 04-25-91 Name: ROB HENDERSON Title: ASST UNDERWRITER

A Lloyd's London Correspondent

UPSHUR COUNTY

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SECTION IV AGGREGATE

- 1) Employees by benefit: MEDICAL
- Single/Attachment Factor: 46/280.92
- Family/Attachment Factor: 76/280.92
- Total employees: 122
- 3) Premium per ee per month: 4.71
- 4) Minimum Attachment Point: \$411,266.88 5) Maximum Indemnity: \$1,000,000
- 6) Type of Contract: Paid
Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91 which are paid during the Period of Insurance. Claims incurred prior to 06-01-91 are limited to \$28,800
- 7) Estimated Annual Premium: \$6,895.44 Deposit Premium: \$574.62 Minimum Premium: \$4,800
- 8) Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)
- 9) Specific is required with purchase of Aggregate

SECTION V SPECIFIC

- | 1) | DEDUCTIBLE | SINGLE/RATE | FAMILY/RATE | DEPOSIT PREMIUM | EST ANNUAL PREMIUM | MINIMUM PREMIUM |
|----|------------|-------------|-------------|-----------------|--------------------|-----------------|
| | 25,000 | 46/33.50 | 76/83.75 | 7,906.00 | 94,872.00 | 66,400 |
- 2) Coinsurance by insured: 0% excess of Deductible.
 - 3) Maximum Indemnity: \$1,000,000
Maximum Aggregate Indemnity for all Specific Excess Claims combined during the Period of Insurance: \$2,000,000
 - 4) Type of Contract: Paid (Annual Deductible per person, ALL cause)
Paid Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91
 - 5) Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)

SECTION VI ADDITIONAL REQUIREMENTS

This tentative proposal is subject to revision pending our receipt of the following:

SEE ATTACHED

SECTION VII NOTES

Benefits: \$500 deductible (2x family); 80/20% to \$5000; Dental (current benefits); PCS EXCLUDED
This proposal replaces and voids all others issued from this office regarding Upshur County prior to this date.

Date: 04-25-91

Name: ROB HENDERSON

Title: ASST UNDERWRITER

Lloyd's London Correspondent

UPSHUR COUNTY

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SECTION IV AGGREGATE

- 1) Employees by benefit: MEDICAL
 - Single/Attachment Factor: 46/275.81
 - Family/Attachment Factor: 76/275.81
 - Total employees: 122
- 3) Premium per ee per month: 4.71
- 4) Minimum Attachment Point: \$403,785.84
- 5) Maximum Indemnity: \$1,000,000
- 6) Type of Contract: Paid

Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91 which are paid during the Period of Insurance. Claims incurred prior to 06-01-91 are limited to \$28,300
- 7) Estimated Annual Premium: \$6,895.44 Deposit Premium: \$574.62 Minimum Premium: \$4,800
- 8) Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)
- 9) Specific is required with purchase of Aggregate

SECTION V SPECIFIC

- | 1) | DEDUCTIBLE | SINGLE/RATE | FAMILY/RATE | DEPOSIT PREMIUM | EST ANNUAL PREMIUM | MINIMUM PREMIUM |
|----|------------|-------------|-------------|-----------------|--------------------|-----------------|
| | 25,000 | 46/33.50 | 76/83.75 | 7,906.00 | 94,872.00 | 66,400 |
- 2) Coinsurance by insured: 0% excess of Deductible.
 - 3) Maximum Indemnity: \$1,000,000

Maximum Aggregate Indemnity for all Specific Excess Claims combined during the Period of Insurance: \$2,000,000
 - 4) Type of Contract: Paid (Annual Deductible per person, ALL cause)

Paid Expenses accrued prior to the Period of Insurance are limited to those incurred on or after 04-01-91
 - 5) Service Charge and/or Surplus Lines Tax: 4.85%+(1.004) of Annual Premium (Do NOT remit to CIG unless account is located in Indiana, Illinois, or Kentucky)

SECTION VI ADDITIONAL REQUIREMENTS

This tentative proposal is subject to revision pending our receipt of the following:

SEE ATTACHED

SECTION VII NOTES

Benefits: \$500 deductible (2x family); 80/20% to \$10000; Dental (current benefits); PCS EXCLUDED
This proposal replaces and voids all others issued from this office regarding Upshur County prior to this date.

Date: 04-25-91

Name: ROB BERDERSON

Title: ASST UNDERWRITER

Lloyd's London Correspondent

UPSHUR COUNTY

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ADDITIONAL REQUIREMENTS CONTINUED

This tentative proposal is subject to revision pending our receipt of the following:

- 1) Confirmation TPA and insured are unaware of any potential losses which are likely to penetrate the Specific deductible.
- 2) Complete information pertaining to individual claims in excess of 50% of the Specific deductible (whether paid or pending), including dx, px, current and anticipated treatment and costs.
- 4) Complete information/APS for claimant(s) INDIVIDUAL W/ MYOCARDIAL INFARCTION, INDIVIDUAL W/ EMPHYSEMA. A higher deductible and/or coinsurance may be required.
- 5) Confirmation DENTAL AND PCS claims are included in claims experience provided.
- 6) Monthly paid claims/enrollment for the period 4-1-91 to 6-1-91.

BENEFIT PLAN #1

The rates below shall include coverages or exclusions as specified in the current benefit specifications.

Failure to submit a policy that provides for all of the benefits, coverages, and exclusions specified will result in your proposal being rejected.

<u>SPECIFIC STOP LOSS</u>	<u>\$25,000</u>
Employee (125)	<u>\$52.82</u>
Dependent (66)	<u>\$76.90</u>
Estimated Annual	<u>\$140,135.00</u>

<u>AGGREGATE STOP LOSS</u>	
Per Employee Per Month	
Monthly Aggregate Cap	Included <u>below</u>
Estimated Annual	<u>\$8,250.00</u>

<u>MAXIMUM AGGREGATE CLAIMS FUND</u>	
Employee (125)	<u>\$216.75</u>
Employee/Dependent (66)	<u>\$295.12</u>
Total Annual	<u>\$558,860.00</u>

<u>TERM LIFE PLAN</u>	
Volume: <u>\$1,924,000</u>	
Term: <u>\$.51/\$1,000</u>	
AD&D: <u>\$.06/\$1,000</u>	
Estimated Annual	<u>\$13,160.00</u>

Above rates will be guaranteed 12 months effective 6-1-91.

Signature _____

Title _____

Company SAFECO



EXCESS LOSS QUOTE

SAFECO LIFE INSURANCE COMPANY
P. O. Box 830586
Richardson, TX 75083-0586

MAIL TO	RISK FUNDING	ATTN	TOM SLACK
Case	UPSHUR COUNTY		

AGGREGATE EXCESS LOSS		<input checked="" type="checkbox"/> Paid
		<input type="checkbox"/> Incurred & Paid
Factors	\$ 216.75 /Employee	\$ 295.12 /Dependent
Assumed # of Units	125 Employees	66 Dependents
Estimated Annual Aggregate Deductible: \$ 558,860		Minimum aggregate deductible equals first month deductible x 12 x 95% and the monthly deductible cannot reduce more than 5% from the prior month
AGGREGATE PREMIUM	To exclude commissions, multiply by .90	
\$ 7,500		

Individual Excess Loss (12 month incurred paid)		Coinsurance 100%		Maximum \$1,000,000	
Individual Deductible	\$ 25,000	\$ 27,500	\$ 30,000	\$	\$
Rates To exclude commissions multiply by 90	EE \$ 52.82	\$ 47.38	\$ 41.19	\$	\$
	Dep \$ 76.90	\$ 68.97	\$ 59.96	\$	\$
Estimated Annual Premium	\$ 140,135	\$ 125,695	\$ 109,273	\$	\$

Life Schedule.	1 X SALARY, MAX 50,000	ADEA Schedule A unless otherwise noted Quote assumes no retiree life coverage.	
Life Volume	1,924,000	Proof of Good Health on amounts above.	N/A
Commission	15 %	<input type="checkbox"/> Contributory	AD&D RATE: .06
Life Rate	.51	<input checked="" type="checkbox"/> Non-Contributory	
Dep Life	3,000 / 2,000	Dep. Life Rate:	1.55 Children To Age: 23
Short Term Disability Aggregate Factor		/\$10. STD Plan	
STD Schedule of Benefits:		STD Volume.	
Notes.			

This quote is good for an effective date of not later than: All rates are contingent upon final plan and enrollment. 6-1-91			
Conversion. \$ 50/ee/month	Coverage included in aggregate:	<input checked="" type="checkbox"/> Medical <input checked="" type="checkbox"/> Dental <input type="checkbox"/> A&S (optional)	<input checked="" type="checkbox"/> PCS Card <input type="checkbox"/> Vision <input type="checkbox"/> A&S (required)

Underwriter: JANET BEATTY - GROUP REPRESENTATIVE/DALLAS	Date: 4-23-91
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EXCESS LOSS QUOTE

