UNITED HEALTHCARE INSURANCE COMPANY

A Stock Company
185 Asylum Street Hartford, CT 06103-3408

APPLICATION FOR EXCESS LOSS INSURANCE

The undersigned Applicant requests the Excess Loss Insurance Benefits shown herein and provided by United HealthCare Insurance Company, and agrees to be bound by the terms and provisions of the Excess Loss Insurance Policy.

Full Legal Name of Applicant: County of Pinellas Board of County Commissioners
Address 400 S. Fort Harrison, Clearwater, FL 33756
Key Contact: Kelly Faircloth Telephone: 727-464-3316 Tax ID:

Applicant is a : ___ Corporation ___ Labor Union ___ Partnership ___ Association ___ Proprietorship ___ Other: X
Nature of Business of the Group to be Insured: County Government Requested Effective Date 01/01/2025

Total number of eligible persons: Employees 3,483 Retirees ___
Are retirees covered: Yes ___ No X

Affiliates or Subsidiaries: **Addresses of Affiliates or Subsidiaries:**

Full Name of Administrator: UMR
Address: ___
Key Contact: ___ Telephone: ___

Agent or Broker: ___
Tax ID: ___
Address: ___

SPECIFIC EXCESS LOSS INSURANCE: X YES ___ NO

Benefit Period: Covered Expenses Incurred from 01/01/2024 Through 12/31/2025
And Paid From 01/01/2025 Through 12/31/2025

Specific Deductible per Covered Person: $650,000
Specific Percentage Reimbursable: 100%
Maximum Specific Benefit per Covered Person:
___ $500,000 ___ $1,000,000 ___ $2,000,000 X Other Unlimited

Covered Expenses under Specific Excess Loss: X Medical X Stand Alone Prescription Drug Program
Common Accident Provision: X Yes ___ No

Specific Premium Rates per Month	
Composite	$37.16

Specific Accommodation Reimbursement Endorsement: X Yes ___ Not applicable
Specific Step-Down Deductible Endorsement: X Yes ___ Not applicable
Specific Terminal Liability Endorsement: ___ Yes X Not applicable
Aggregating Specific Deductible Endorsement: ___ Yes X Not applicable

AGGREGATE EXCESS LOSS INSURANCE: ___ YES X NO

It is understood and agreed by the undersigned that:

1. The statements, declarations and representations made in this Application, any request for proposal, the underwriting information provided by or on behalf of the undersigned and the Plan Document are the undersigned's representations; that any Policy is issued in reliance upon the truth of such statements, declarations, and representations; and that such statements, declarations, and representations will form a part of the Excess Loss Insurance Policy. Any inaccuracy in such information or failure to disclose any such information, including all claims or possible claims, paid or pending, or which the Employer should otherwise know about, if discovered later, can result in rejection of this Application, or can change the terms, conditions or premiums, or can void coverage.
2. As a condition precedent to the approval of this Application, the undersigned shall furnish to the Company a copy of the executed Plan Document within 90 days after the date of this application describing the benefits provided by the Plan, which shall be kept on file in the office of the Company. If the Company does not receive the Plan Document within 90 days, the Company may refund all premium and the Application shall have been null and void when signed. No Excess Loss Insurance will be effective nor reimbursement made unless a Plan Document is received and accepted by the Company.
3. The Company will evaluate the undersigned's risk, as requested by this application, the underwriting data received and represented by the Plan and may require adjustments of rates, factors, and/or special limitations.
4. Any coverage resulting from this Application shall be subject to the terms and provisions of the Policy herein applied for. Coverage shall become effective on the date specified in this Application if all requirements of the Company, including the Plan Document and the underwriting requirements have been met and the required premiums paid.
5. The receipt by the Company of the first month's premium and deposit of any check drawn in connection with this Application shall not constitute an acceptance of liability. In the event the Company does not approve this application, its sole obligation shall be to refund such sum to the undersigned.
6. The undersigned will provide or employ an Administrator to administer the Plan and to process and pay claims according to the Plan Document. The undersigned acknowledges that the Administrator is the undersigned's agent and not the agent of the Company and that statements and answers given by the Administrator are binding on the undersigned.
7. **No New Laser/40% Rate Cap applies for the renewal period of 1/1/2026 - 12/31/2026. Rate increase applies to a matured current rate and is not extended beyond the next renewal.**
8. **Claimant 1 specific deductible is $750,000.**
9. **Claimant 2 specific deductible is $1,000,000**

The undersigned has read the entire Application for Excess Loss Insurance and understands that the insurance requested herein is not in effect until this Application is approved and accepted by the Company.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Full Legal Name of Applicant: County of Pinellas Board of County Commissioners

Signature of Authorized Person: _____ ATTEST: KEN BURKE, CLERK By: _____ SEAL

Print Name: Kathleen Peters Title: Chair

Date: December 17, 2024.

Signature of Agent or Broker: Charles Tobin

Print Name of Agent or Broker: Charles Tobin

License No.: A265939

APPROVED AS TO FORM

By: *Marshall Brannon*

Office of the County Attorney

UHIAPP-FL (12/01)