Declaration of Signature

It is Agreed that all statements, representations and answers made in this Application are considerations for and a basis of the contract(s) between the Applicant and CHLIC. Whether written, electronically received or printed, they are declared to be true, full and complete. No other statement, representation, or information will bind CHLIC or affect its rights. The Applicant will promptly send to CHLIC full particulars as to each employee to become covered or with a change to coverage at any time under the policy(s)/plan(s) to the satisfaction of CHLIC. The Applicant agrees that all payments to be made to CHLIC are the sole responsibility of the Applicant. CHLIC will not be responsible for the actions or inactions of any third party that the Applicant may use to transmit information or payments to CHLIC.

The undersigned Signatory hereby states, affirms, represents and warrants that by affixing the Signatory's signature in the space provided below, that said signature, appearing solely on this document, shall and does constitute the Signatory's signature to each and every document, contract or agreement herein listed or described with the same force and effect as if the Signatory had separately and affirmatively affixed the Signatory's signature to such document, contract or agreement. Upon approval of this Application, documents reflecting the elections made by the Applicant in this Application will be issued. Once issued, all terms and conditions become effective as of the effective date.

Signatory, by affixing the Signatory's signature in the space provided below does hereby state, affirm, represent and warrant that:

i. The Signatory does hereby affix Signatory's signature to this document freely, voluntarily and without coercion of any kind or nature whatsoever.
ii. that except as provided below, Signatory hereby waives and shall not assert any position, claim, defense, or counterclaim that states or implies anything contrary to the content of this document except for forgery, fraud or unlawful physical duress.
iii. Any policy or contract issued based on this Application, together with any of its amendments or riders, shall control the insurance coverage and terms and conditions of such insurance. In the event of a conflict between the Application and the terms of the Policy or Contract, the Policy or Contract shall prevail.
iv. this Signature Declaration shall be part of each and every document, contracts or agreement herein listed and
v. a copy of this document shall have the same force and effect as the original.

Documents, contracts and agreements listed herein means:

Stop Loss Agreement; Administrative Services Agreement;

If applicable:
Performance Guarantee Agreement(s).

This Application must be approved by the CHLIC corporate office located in Greenwood Village, Colorado. No Plan is in effect until the Application has been approved. CHLIC reserves the right to reject any Application. If at any time after the effective date of this coverage there is a change in participation under this Plan, either: a) 10% in any one month when compared to the previous month; or b) 20% over any period of three consecutive Policy Months; then CHLIC reserves the right to adjust the rates or factors.

Full Legal Name of the Firm: Fremont County

Effective Date: 01/01/2025

Applicant Signature: _____ **Dated:** 10-30-24

Printed Name: Dwayne McFall **Title:** Commissioner

Application For Group Coverage -- Signature Pages:

CONSENT TO ELECTRONIC DELIVERY OF INSURANCE POLICY DOCUMENTS

☐ Applicant elects non-electronic delivery of all insurance policy documents (including certificates)

☒ Applicant consents to electronic delivery of all insurance policy documents (including certificates). In making this election, Applicant acknowledges that it is aware that:

- it has the option of electing to have paper copies of the documents delivered;
- it may withdraw its consent to electronic delivery at any time in the future by making a written request to Cigna;
- withdrawal of consent to electronic delivery of insurance policy documents shall be effective 10 business days following receipt of the request by Cigna;
- withdrawal of consent to electronic delivery shall not affect the legal effectiveness, validity, and/or enforceability of any insurance policy documents delivered electronically prior to the effective date if its withdrawal, and
- an additional charge may be required for any insurance policy documents that are not delivered electronically.

Application For Group Coverage -- Signature Pages:

State law of Vermont requires the following notice:

NOTICE: Small employers with self-funded health plans should not consider the purchase of stop loss coverage as elected in this Application as complete protection from all liability created by the self-funded health plan. Small employers should be aware that failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded plan may cause the small employer to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny reimbursement under the stop loss policy. In addition, small employers may experience higher claim volatility due to fewer enrolled members and low-frequency, high-cost, claim utilization.

State law of Minnesota requires the following notice:

THE STOP LOSS POLICY IS NOT PROTECTED BY THE MINNESOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION OR THE MINNESOTA INSURANCE GUARANTY ASSOCIATION. IN THE CASE OF INSOLVENCY, PAYMENT OF CLAIMS IS NOT GUARANTEED. ONLY THE ASSETS OF THIS INSURER WILL BE AVAILABLE TO PAY YOUR CLAIM.

State law of Mississippi requires the following notice:

IMPORTANT NOTICE ABOUT THE STOP LOSS POLICY FOR WHICH YOU (APPLICANT) HAVE APPLIED. THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS. READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.

2. The arbitration agreement requires that any dispute related to the policy must be resolved by arbitration and not in a court of law.

3. The results of the arbitration are final and binding on you and the insurance company.

4. In an arbitration proceeding, one or more arbitrators, who are independent, neutral decision makers, render a decision after hearing the positions of the parties.

5. When you accept the insurance policy, you agree to resolve any dispute related to the policy by binding arbitration instead of a trial in court, including a trial by jury.

6. Binding arbitration generally takes the place of resolving disputes by a judge and jury.

7. Should you need additional information regarding the binding arbitration provision in the policy, you may contact our toll free assistance line at 1-866-244-8081.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT:

By my signature below, I acknowledge that I have read this statement. I understand that I am voluntarily surrendering the Applicant's right to have any dispute between the insurance company and myself resolved in court. This means that I am waiving the Applicant's right to a trial by jury.

Application For Group Coverage -- Signature Pages:

State law of Oregon requires the following notice:

FRAUD WARNING: 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 commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Puerto Rico requires the following notice:

FRAUD WARNING: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; and if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

State Law of Vermont requires the following notice:

FRAUD WARNING: 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 committing a fraudulent insurance act, which may be a crime subject to civil or criminal penalties.

State law of Virginia requires the following notice:

FRAUD WARNING: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be in violation of state law.

State law of Washington requires the following notice:

FRAUD WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The following notices apply to Stop Loss coverage:

State law of Arkansas requires the following notice:

NOTICE: Employers/plan sponsors of self-funded health plans should not consider the purchase of stop loss coverage and /or excess loss coverage as complete protection from all liability created by the self-funded health plan. Employer/plan sponsors should be aware that the failure to comply with the terms of the stop loss policy and/or the provisions in the self-funded plan may cause the employer/plan sponsor to incur liabilities under the health plan. For instance, if medical claims are paid on an ineligible individual, the stop loss carrier may deny the reimbursement under the stop loss policy. In addition, the Arkansas Life and Health Insurance Guaranty Association does not cover claims reimbursable under a stop loss policy.

State law of Louisiana requires the following notice:

Applicant hereby agrees and understands that the stop-loss insurance policy coverage selected does not provide reimbursement to the plan sponsor for any expenses incurred under the Benefit Plan prior to the beginning of the policy period for stop-loss insurance or for any expenses paid after expiration of the policy period. Only eligible expenses that are both incurred under the Benefit Plan and paid by the Benefit Plan within the policy period for stop-loss insurance are reimbursable under the policy selected.

If Applicant declines Run-In coverage by selecting N/A, Applicant hereby agrees and understands that the stop-loss insurance policy coverage selected does not provide reimbursement to the plan sponsor for any expenses that are not paid by the Benefit Plan within the current policy period, unless the policy is subsequently renewed. Only eligible expenses that are both incurred and paid by the Benefit Plan within the stated policy period are reimbursable under the policy selected.

Application For Group Coverage -- Signature Pages:

Please note the terms Stop Loss and Excess Loss may be used interchangeably throughout this document.

FRAUD WARNING: 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, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

State Law of Alabama requires the following notice:

> FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

District of Columbia requires the following notice:

> **WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the Applicant.**

State law of Florida requires the following notice:

> **FRAUD WARNING: 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.**

State law of Georgia requires the following notice:

> **The self-funded welfare benefit plan of the Plan Sponsor is not regulated nor approved under the insurance laws of Georgia.**

State Law of Kentucky requires the following notice:

> FRAUD WARNING: 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, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

State law of Louisiana requires the following notice:

> **FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

State law of Maryland requires the following notice:

> Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

State law of New York requires the following notice:

> **FRAUD WARNING: 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, commits a fraudulent insurance act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

State Law of Oklahoma requires the following notice:

> **WARNING: Warning: Any person who knowingly and with intent to injure, defraud or deceive any insurer , makes a claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

Application For Group Coverage -- Signature Pages:

NOTE: This document is important. It affects your legal rights and obligations.
This Application is for employee benefit coverage or administration provided by Cigna Health and Life Insurance Company (CHLIC).

Other Benefits: ☐ **None**

If there are any additional benefits not previously indicated, please identify them here. In the Benefit column, list coverage affected, then in Description column describe the benefit. There will be an extra cost for each additional benefit listed. You may list up to 4 additions.

Benefit	**Description**
_____	_____
_____	_____
_____	_____
_____	_____

The Applicant understands that CHLIC will provide Booklets electronically to the Applicant. The Applicant is responsible for distributing booklets (electronically or otherwise) to employees.

The Applicant accepts and agrees that approval of the Application and the final rates, fees, and factors so determined will be based on the final enrollment and eligibility information provided to CHLIC by the Applicant, including the final proportion of employees electing coverage under the contract(s) for which Application is made. Approval and final rates, fees and factors will also be subject to qualification under the current underwriting rules and practices. Underwriting rules which are used by CHLIC, which include but are not limited to:

- CHLIC is the sole provider of medical expense benefits.
- No more than 10% of eligible employees will be covered under a retiree class of benefits.
- There have been no more than 2 prior carriers in the past 4 years.
  Carrier/ Dates of Coverage
  1)
  2)
- The number of employed family members related to all company officers will be less than or equal to the larger of 5 or 10% of the number of eligible employees.
- The Applicant will fund 50% of total plan costs or 100% of employee costs.
- Employee participation minimum standards that more than 75% of eligible employees will apply for coverage under the medical plan.
- Dependent participation minimum standards that more than 85% of employees with eligible dependents, excluding those who elect to waive benefits (dependents covered under another plan), will apply for dependent coverage under the medical plan.
- Life insurance standard that the average certificate amount for one class can be no greater than 2½ times the average certificate of the next lower class, and/or that there must be at least 2 employees per class excluding the highest class, which may include just 1 employee.

3. provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision ofsection 2807-j of the Public Health Law (see note below).

5. The Department's website posting of the above entity's FEIN in accordance with Public Health Law Section 2807-j(5)(a)(iii)(D).

By signature below, the above entity also agrees to make public goods covered lives payments directly to the Department's Office of Pool Administration in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund, or a commercial insurer licensed to do business in New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's Office of Pool Administration within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;

2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and

3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law (see note below).

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments has been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature: _____ **Title:** Comm. Ss. oner
(Chief Financial Officer or Duly Authorized Individual)

Date: 10-30-24

***Note:** Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.*

NEW YORK STATE DEPARTMENT OF HEALTH

Division of Health Care Financing **Payor Election Application**

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: 01/01/2025

Federal Employer Identification # (FEIN): 846000765

Payor Name: Fremont County

D/B/As (if applicable):

Address: 615 Macon Ave.

Canon City , Colorado 81212

Contact Person: Dwayne McFall

Phone #: 719-276-7411

E-Mail Address: dwayne.mcfall@fremontco.com

If the above referenced entity is a payor that utilizes a third party administrator (TPA)/administrative service only (ASO) for claims processing please provide the following information:

TPA/ASO Name: Cigna Health and Life Insurance Company

TPA/ASO FEIN: 59-1031071

By signature below, the above entity elects to make public goods surcharge payments directly to the Office of Pool Administration for all its coverages for which it assumes risk for the payment of medical claims and agrees to:

1. remit to the Department's Office of Pool Administration required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;

2. provide the Department's Office of Pool Administration monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory[1], or ambulatory surgery center) by product line;

[1] For services provided on or after October 1, 2000, freestanding clinical laboratories with Article 5 Title V permits are exempt from HCRA surcharges.

NEW YORK STATE DEPARTMENT OF HEALTH

Division of Health Care Financing **Electronic Filing User ID Application**

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

[X] **New Request** [ ] **Revision to Existing Account**

Payor/Third Party Administrator/Administrative Services Only Organization/Provider Name:

Fremont County

Federal Employer Identification # (FEIN): 846000765

Report(s) being filed electronically (check ALL that apply):

[X] Public Goods Pool

[ ] 1% Statewide Assessment ***(for providers only)***

[ ] Health Facility Cash Receipts Assessment ***(for providers only)***

By signature below, the Chief Financial Officer or other duly authorized individual of the above named entity authorizes the Office of Pool Administration to assign a secure electronic filing user ID and password to the entity. This information will be mailed directly to the attention of the signer and must remain secured. It is the responsibility of the above named entity to ensure that this information is released only to those individuals requiring knowledge thereof.

Signature: D McFall

Name: **Dwayne McFall**

Title: Chairman of the Board of County Commissioner's

Phone Number: 719-276-7411

Address: 615 Macon Ave.

City: Canon City **State:** CO **Zip:** 81212

E-mail Address: dwayne.mcfall@fremontco.com

Date: 10-30-24

Note: *All fields on this form are required to be accurately completed in order for your request to be processed.*

NEW YORK STATE DEPARTMENT OF HEALTH

Division of Health Care Financing **Payor Election Application**

COVERAGE INFORMATION

Payor Name: Fremont County **Federal ID #:** 846000765

TPA Name: Cigna Health and Life Insurance Company **TPA/ASO Federal ID #:** 59-1031071

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE:									
	INDEMNITY COVERAGE	HMO NON-MEDICAID COVERAGE	SELF-INSURED COVERAGE	NEW YORK STATE HMO/PHSP MEDICAID COVERAGE	NEW YORK STATE GOV'T PROGRAM W/INPATIENT COMPONENT & NYS LOCAL GOV'T CORRECTIONS	NEW YORK STATE WORKERS COMPENSATION LAW COVERAGE	NEW YORK STATE MOTOR VEHICLE REPARATIONS ACT COVERAGE	NEW YORK STATE VOLUNTEER AMBULANCE WORKER'S BENEFIT LAW COVERAGE	NEW YORK STATE VOLUNTEER FIREFIGHTER'S BENEFIT LAW COVERAGE	OTHER COVERAGE
Corporations Organized & Operating in accordance withArticle 43 of the Insurance Law										
Corporations that are Commercial Insurers licensed in New York State										
Corporations Organized & Operating in accordance with Article 44 of the Public Health Law, not incorporated as Commercial Insurers or under Article 43 of the Insurance Law										
Self-Insured Fund with No Third Party Administrator/Administrative Svcs Only Organization for Claims Processing										
Self-Insured Fund with a Third Party Administrator/Administrative Svcs Only Organization for Claims Processing			X							
New York State Governmental Agency/New York State Local Governments										
Other (please explain below)(Includes State/Local Governments other than New York and Commercial Insurers and HMOs not licensed in NYS)										

Explanation of "Other" Payor Identification:

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Health Care Financing

Third Party Administrator (TPA) or Administrative Services Only (ASO) Status Change

HEALTH CARE REFORM ACT – PUBLIC GOODS POOL

Effective Date: 01/01/2025

PAYOR INFORMATION:

Payor Name: Fremont County **Payor FEIN #:** 846000765

Contact Person: Dwayne McFall **Phone #:** 719-276-7411

Type of Status Change (check appropriate box):

☐ **Additional TPA/ASO** (complete Section II only)

☒ **Changing TPA/ASO** (complete Sections I, II, & III)

I. PREVIOUS TPA/ASO INFORMATION:

TPA Name: CEBT/UMR TPA Federal ID #: _____

II. NEW or ADDITIONAL TPA/ASO INFORMATION:

TPA Name: Cigna Health and Life Insurance Company TPA Federal ID #: 59-1031071

Address: 2000 S. Colorado Blvd
Tower 3, Suite 1100
Denver, CO 80222

TPA Contact Person: Sylvia Zeigler TPA Phone #: 770-261-4937

III. CHECK ONE OF THE FOLLOWING:

☒ Previous TPA will continue to process claims and file reports for all dates of service prior to the change for a period of one year following the end of the year in which the change in TPA occurred or until all such claims have been adjudicated, at which time a final monthly report with a copy of this form indicating same will be filed.

☐ All self-insured claims that previous TPA was responsible for have been adjudicated effective _____

☐ New TPA is assuming responsibility for all pending claims and HCRA reporting requirements.

Signature of Payor: [signature] **Date:** 10-30-24