RESOLUTION NO. ____

A RESOLUTION AUTHORIZING EXECUTION OF AN AGREEMENT BETWEEN THE VILLAGE OF DOWNERS GROVE AND CHUBB GROUP OF INSURANCE COMPANIES

BE IT RESOLVED by the Village Council of the Village of Downers Grove, DuPage County, Illinois, as follows:

1. That the form and substance of a certain Employer Stop Loss Application (the "Agreement"), between the Village of Downers Grove (the "Applicant") and Chubb Group of Insurance Companies (the "Provider"), for stop loss insurance coverage, as set forth in the form of the Agreement submitted to this meeting with the recommendation of the Village Manager, is hereby approved.

2. That the Village Manager and Village Clerk are hereby respectively authorized and directed for and on behalf of the Village to execute, attest, seal and deliver the Agreement, substantially in the form approved in the foregoing paragraph of this Resolution, together with such changes as the Manager shall deem necessary.

3. That the proper officials, agents and employees of the Village are hereby authorized and directed to take such further action as they may deem necessary or appropriate to perform all obligations and commitments of the Village in accordance with the provisions of the Agreement.

4. That all resolutions or parts of resolutions in conflict with the provisions of this Resolution are hereby repealed.

5. That this Resolution shall be in full force and effect from and after its passage as provided by law.

____
Mayor

Passed:
Attest: _________________________
Village Clerk

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Chubb Group of Insurance Companies
15 Mountain View Road
Warren, New Jersey 07059

EMPLOYER STOP LOSS APPLICATION

BY COMPLETING THIS APPLICATION YOU ARE APPLYING FOR COVERAGE WITH FEDERAL INSURANCE COMPANY (THE "COMPANY")

APPLICATION INSTRUCTIONS:

1. Whenever used in this Application, the term "**Applicant**" shall mean the insured and all subsidiaries.
2. Include all requested underwriting information and attachments. Provide a complete response to all questions and attach additional pages if necessary.

I. GENERAL INFORMATION

1. Name of Applicant: Village of Downers Grove
2. Address of Applicant: 801 Burlington Ave.

   City: Downers Grove State: IL Zip Code: 60515 Telephone: 630-434-5500
3. Web address: www.downers.us
4. Name and Address of Primary Contact: Mary Weisenburn

   City: Downers Grove State: IL Zip Code: 60515 Telephone: 630-434-5538
5. Other Location(s): ☐ Yes ☐ No
   If Yes, please give name and complete address of any/all including number of employees at each location.
6. Are subsidiary/affiliated/associated companies to be included under this benefit plan? ☐ Yes ☐ No
   If Yes, please state the legal name, location(s), and number of employees for each (companies under common control through stock ownership, contract or otherwise to be included):

II. SPECIFIC INFORMATION:

1. Enter the full name of your benefit plan(s): (A copy of such executed benefit plan(s), including all amendments, must be attached.)

   Village of Downers Grove Group Health Plan
2. Nature of **Applicant's** Primary Business: (SIC Code) **9110**
3. Federal Employer's Tax I.D. #: E 9997-4479-05
   Number of Years in Business: ____________

   ☐ Corporation ☐ Partnership ☐ Proprietorship ☒ Other

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EMPLOYER STOP LOSS APPLICATION

4. Estimated Initial Enrollment:

124	Single/Employee only		COBRA Beneficiaries
	Employee and Spouse	91	Retired Employees
	Employee and Child(ren)		
242	Family (Employee/Spouse/Children)		

5. Proposed Effective Date: **1/1/10**

6. Name and Address of Designated Third Party Administrator:
(Firm) **Professional Benefit Administrators**
(S.S.N. or Tax I.D.#) **36-338-4135**
(Address) **900 Jorie Blvd**
(Contact Person & Phone Number) **Karen Berg-Raftakis 630-655-3755 Ext 255**

III. POLICY PERIOD:

1. Policy Period Requested:
From **1/1/10** to **1/1/11** both days at 12:01 a.m. at the principal address of the insured.

2. Covered Persons Included:
   a. Retired Employees: XX Yes No
   b. COBRA Beneficiaries ☒ Yes ☐ No
   c. Disabled Persons ☒ Yes ☐ No

3. Actively At Work Provision

☐ Actively At Work Provision Applies
☒ Actively At Work Provision Waived (with Company approval and completed employer disclosure statement)

IV. REQUESTED COVERAGE:

A. Specific Stop Loss Insurance Requested:

1. Requested Under the Policy: ☒ Yes ☐ No

2. Requested Services To Include:

Medical	☒ Yes	☐ No
Prescription Drug	☐ Yes	☒ No
Prescription Drug Card	☒ Yes	☐ No

3. Requested Services Incurred From: **1/1/09** To: **12/31/10**

4. Specific Retention Amount Per Covered Person Per Policy Period: $**125,000.00**

5. Insured Percentage: **100** %

6. Paid by the Insured From: **1/1/10** To **12/31/10**

7. Claim Reporting Deadline: **2/28/11**

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8. Maximum Specific Benefit Per Covered Person:
   A. Per Policy Period: $1,875,000.00
   B. Lifetime Maximum Per Covered Person: $ 1,875,000.00

9. Specific Monthly Premium Rates:
   $ 34.96 Per Single/Employee Only Covered Unit
   $______ Per Employee and Spouse Covered Unit
   $______ Per Employee and Child(ren) Covered Unit
   $ 92.11 Per Family (Employee/Spouse/Children) Covered Unit

B. Aggregate Stop Loss Insurance Requested:

1. Requested Under the Policy: ☐ Yes ☒ No

2. Requested Services to Include:

Medical	☐ Yes	☐ No	STD/Weekly Disability Income	☐ Yes	☐ No
Dental	☐ Yes	☐ No	Prescription Drug	☐ Yes	☐ No
Vision	☐ Yes	☐ No	Prescription Drug Card	☐ Yes	☐ No

3. Requested Services Incurred From: ______ To: ______

4. Run-in Limit (if applicable):
   A. Covered services Incurred from: ______ To: ______
   B. Not to exceed: $______

5. Minimum Aggregate Retention Per Policy Period: $______

6. Monthly Aggregate Factors:
   $______ Per Single/Employee Only Covered Unit
   $______ Per Employee and Spouse Covered Unit
   $______ Per Employee and Child(ren) Covered Unit
   $______ Per Family (Employee/Spouse/Children) Covered Unit

7. Insured Percentage: ______%

8. Paid by the Insured From: ______ To: ______

9. Claim Reporting Deadline: ______

10. Maximum Aggregate Benefit Per Policy Period: $______

11. Aggregate Monthly Premium Rates:

   $______ Per Single/Employee Only Covered Unit
   $______ Per Employee and Spouse Covered Unit
   $______ Per Employee and Child(ren) Covered Unit
   $______ Per Family (Employee/Spouse/Children) Covered Unit

C. Additional Options Requested:

1. Monthly Aggregate Cap Option Requested: ☐ Yes ☒ No

2. Terminal Liability Option Requested: ☐ Yes ☒ No

3. Specific Advance Option Requested: ☒ Yes ☐ No
4. $__________ Terminal Liability Risk Premium Per Employee

5. Terminal Liability Attachment Factors:
   $_______________Per Single/Employee Only Covered Unit
   $_______________Per Employee and Spouse Covered Unit
   $_______________Per Employee and Child(ren) Covered Unit
   $_______________Per Family (Employee/Spouse/Children) Covered Unit

D. Representation: Prior Knowledge of Facts/Circumstances/Situations:

No person or entity proposed for coverage is aware of any fact, circumstance, or situation which he or she has reason to suppose might give rise to any claim that would fall within the scope of the proposed coverage, except: NONE ______ or ____
____
____
____.

Without prejudice to any other rights and remedies of the Company, the **Applicant** understands and agrees that if any such fact, circumstance, or situation exists, whether or not disclosed above, any claim or action arising from such fact, circumstance, or situation is excluded from the proposed coverage if a policy is issued by the Company.

V. MATERIAL CHANGE:

If there is any material change in the answers to the questions in this Application before the policy inception date, the **Applicant** must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

VI. NOTICES:

Receipt of any money in connection with this Application shall not constitute an acceptance of liability. In the event the Company disapproves this Application, its sole obligation shall be to refund such sum to the **Applicant**.

The Applicant's submission of this Application does not obligate the Company to issue a policy. The **Applicant** will be advised if the Application for coverage is accepted. The **Applicant** authorizes the Company to make any inquiry in connection with this Application.

Notice to Arkansas, Louisiana, Maryland, Minnesota, New Mexico and Ohio Applicants: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false, fraudulent or deceptive statement is, or may be found to be, guilty of insurance fraud, which is a crime, and may be subject to civil fines and criminal penalties.

Notice to Colorado Applicants: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory agencies.

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REQUIRED ARKANSAS 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. Employers/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 health 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.

PRODUCED BY ***(Insurance Agent)***	**INSURANCE AGENCY**
INSURANCE AGENCY TAXPAYER ID OR SOCIAL SECURITY NO.	**AGENT LICENSE NO.**
ADDRESS ***(No., Street, City, State, and ZIP Code)***	
EMAIL ADDRESS	

SUBMITTED BY ***(Insurance Agency)***	**INSURANCE AGENCY TAXPAER ID OR SOCIAL SECURITY NO.**	**AGENT LICENSE NO.**
ADDRESS ***(No., Street, City, State, and ZIP Code)***		

EMPLOYER STOP LOSS APPLICATION

Notice to District of Columbia: 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.

Notice to Maine, Tennessee and Virginia Applicants: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Notice to Florida and Oklahoma Applicants: Any person who, knowingly and with intent to injure, defraud or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony (in Oklahoma) of the third degree (in Florida).

Notice to Kentucky Applicants: Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any false information, or conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

Notice to New Jersey Applicants: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Notice to Oregon and Texas Applicants: Any person who makes an intentional misstatement that is material to the risk may be found guilty of insurance fraud by a court of law.

Notice to Pennsylvania and New York Applicants: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (in New York) or criminal and civil penalties (in Pennsylvania).

Notice to Washington Applicants: 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.

VII. DECLARATION AND SIGNATURE:

For the purposes of this Application, the undersigned authorized agents of the person(s) and entity(ies) proposed for this insurance declare to the best of their knowledge and belief, after reasonable inquiry, the statements made in this Application and any attachments or information submitted with this Application, are true and complete. The undersigned agree that this Application and its attachments shall be the basis of a contract should a policy providing the requested coverage be issued and shall be deemed to be attached to and shall form a part of any such policy. The Company will have relied upon this Application, its attachments, and such other information submitted therewith in issuing the proposed coverage.

The information requested in this Application is for underwriting purposes only and does not constitute notice to the Company under any policy of a claim or potential claim.

This Application must be signed by the chief executive officer and chief financial officer of the Insured acting as the authorized representatives of the person(s) and entity(ies) proposed for this insurance.

Date	Signature	Title
11/17/09	[signature]	Chief Executive Officer *
11/17/09	[signature]	Chief Financial Officer *

* Signatures of Chief Executive Officer and Chief Financial Officer are contingent on Village Council approval.