



QBE INSURANCE CORPORATION
STATE OF DOMICILE: PENNSYLVANIA

APPLICATION FOR STOP LOSS POLICY - TEXAS

Policy Number: **LGS02069-26**

1. Full legal name of Applicant: **City of Farmers Branch** Tax ID Number: **75-6003955**
(as it will appear in the Policy as the "Policyholder")
2. Principal Address:
13000 William Dodson Parkway Farmers Branch, TX 75234
3. Contact Person: **Heather Feeney** Email: **heather.feeney@farmersbranchtx.gov**
4. Nature of Business: **9111 Executive Offices**
5. If Plans of related entities such as subsidiaries, affiliates, divisions or other locations are to be included, list legal names and addresses of such companies or entities and the nature of their business:
6. Full name of Your Plan: **City of Farmers Branch**
A copy of Your Plan Document, and those of any related entities that are to be included shall form a part of the Policy.
7. Desired Policy Effective Date: **January 01, 2026**
8. Endorsements:
Plan Mirroring Endorsement AH-MSL-5003-TX-ER
No New Laser Endorsement AH-MSL-5005-TX-ER
9. Your Designated Third Party Administrator (for purpose of claims administration under Your Plan):
Name: **UMR**
Address: **115 W. Wausau Avenue**
City, State, Zip: **Wausau, WI 54401**
10. Your broker/agent of record:
Name: **Stealth Partner Group**
Address: **5910 N Central Expressway, Suite 500**
City, State, Zip: **Dallas, TX 75206**
11. Your PPO Network is: **UHC - Choice Plus**
12. Your Utilization Review Provider is: **UR Care**
13. Special classes eligible for coverage:
Retirees: Yes ☒ No ☐ Late Entrants: Yes ☐ No ☒
Only pre-65 retirees that are non-Medicare primary are eligible for coverage.

14. Estimated Covered Units:

Covered Unit Description	Units
<u>Composite</u>	<u>370</u>

15. Initial premium deposit accompanying this Application:
(Specific)\$43,900.50 + (Aggregate)\$2,745.40 = \$46,645.90

16. **COVERAGES**

The Coverage shown applies only during the Policy Period from **January 01, 2026** (Desired Policy Effective Date) through **December 31, 2026** (Desired Policy Expiration Date).

A. **SPECIFIC STOP LOSS COVERAGE** ☒ Yes, included ☐ No, not included

1) Coverage to be included (not included unless checked):

☒ Medical ☒ Prescription Drugs

2) Specific Deductible: **\$200,000.00**

Per Covered Person.

3) Aggregating Specific Deductible: **\$80,000.00**

4) Specific Policy Period Maximum Reimbursement: **Unlimited upon satisfaction of Specific Deductible** per Covered Person.

5) Basis of Specific Stop Loss coverage benefit payment (Benefit Period):

Plan Benefits Incurred from **January 01, 2018** through **December 31, 2026**
 and paid from **January 01, 2026** through **December 31, 2026**.

Run-Out Period: **0 days**

Plan Benefits Incurred prior to the Policy Effective Date (the Run-In-Period) will be limited to the following (the Run-In Limit):

N/A per Covered Person

N/A for all Covered Persons combined

6) Premium Rates (per month):

Covered Unit Description	Units	Amount
<u>Composite:</u>	<u>370</u>	<u>\$118.65</u>

7) Estimated Annual Specific Premium: **\$526,806.00**.

B. **AGGREGATE STOP LOSS COVERAGE** ☒ Yes, Included ☐ No, not included

1) Coverage to be included (not included unless checked):

☒ Medical ☒ Prescription Drugs

2) Monthly Aggregate Factor(s):

Covered Unit Description	Total	Medical	Prescription Drugs
Employee:	\$1,401.20	X	X

- 3) Estimated Annual Aggregate Attachment Point: **\$6,221,328.00**
- 4) Minimum Annual Aggregate Attachment Point Percentage: **100%**
- 5) Estimated Minimum Annual Aggregate Attachment Point: **\$6,221,328.00 (Estimated)**
- 6) Individual Claim Limit: **\$200,000.00** per Covered Person
- 7) Aggregate Policy Period Maximum Reimbursement (per Policy Period): **\$1,000,000.00**
- 8) Basis of Aggregate Stop Loss coverage benefit payment (Benefit Period):
 Plan Benefits Incurred from **January 01, 2018** through **December 31, 2026**
 and paid from **January 01, 2026** through **December 31, 2026**

Run-Out Period: **0 days**

N/A per Covered Person
N/A for all Covered Persons combined

- 9) Premium Rates (per month):

Covered Unit Description	Amount
<u>Aggregate Composite</u>	<u>\$7.42</u>

- 10) Estimated Annual Aggregate Premium **\$32,945.00**

17. Special Limitations and Additional Information: **N/A**

You have read the foregoing and understand and agree with the terms and conditions of the coverage as set forth by Us and as reflected in this Application. You represent that You have formed Your Plan in compliance with all applicable state and federal laws. It is agreed that the statements in this Application or in any materials submitted with this Application or attached to it, including all disclosure information, are Your representations and shall be deemed material to acceptance of the risk by Us and that the Policy is issued by Us in reliance on the truth and accuracy of such representations. Should subsequent information become known which, if known prior to issuance of the Policy, would affect the premium rates, factors, terms or conditions for coverage thereunder, We will have the right to revise the premium rates, factors, terms or conditions as of the Policy Effective Date, by providing written notice to You. Any fraudulent statement will render the Policy null and void and claims, if any, will be forfeited.

THIS APPLICATION DOES NOT BIND COVERAGE. Upon approval of this Application, the Policy evidencing that the coverage is in force will be issued by Us. Coverage will commence on the Policy Effective Date set forth in the Policy. This Application will attach to and form part of the Policy.

FRAUD WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, submits an application for insurance or makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

ACCEPTED BY THE APPLICANT:

By: _____
(Signature of Officer)

Signed at: _____
(City, State)

Name: _____
(Printed Name of Officer)

Signed on: _____
(Date)

Title: _____
(Title of Officer)

On behalf of: _____
(Legal Name of Applicant Policyholder)

Applicant's Broker/Agent of Record:

(Signature of Broker/Agent of Record)

(Printed Name of Broker/Agent of Record)

ACCEPTED BY QBE INSURANCE CORPORATION:

By: _____
(Signature of Officer)

Signed at: Marblehead, Massachusetts
(City, State)

Name: Tara Krauss
(Printed Name of Officer)

Signed on: _____
(Date)

Title: President of A&H
(Title of Officer)

On behalf of QBE Insurance Corporation