American Fidelity Assurance Company

A member of the American Fidelity Group

(A Stock Company)

2000 N. Classen Boulevard, Oklahoma City, Oklahoma 73106

DISCLOSURE STATEMENT
(Supplement to Application/Schedule)

American Fidelity Assurance Company (AFAC) requires the disclosure of all persons (employees and dependents) covered by the Applicant/Policyholder's self-funded Employee Welfare Benefit Plan who:

1. are COBRA, FMLA, or other continuees;
2. are Retirees;
3. are not actively at work or otherwise disabled (unable to perform the same lifestyle functions as a person of similar age and sex in good health);
4. have incurred medical expenses which exceed the lesser of 50% of the Specific Attachment Point, or $30,000.00, during the 12-month period prior to completion of this Disclosure Statement;
5. have on-going claims; or
6. have a diagnosis, illness, accident, or condition (whether a claim is Paid or pending) which has the potential to be catastrophic (e.g., cancer, premature birth, diabetes, heart disease).

Employees (and their dependents) of any and all companies the Applicant/Policyholder is in the process of acquiring at the time of application, who meet one or more of the above conditions, must also be included on this form. A separate Disclosure Statement must be completed and submitted to AFAC's Underwriting Manager for each additional company that the Applicant/Policyholder acquires after initial application for coverage.

This Disclosure Statement may be completed, in conjunction with receipt of a binder check, no earlier than 30 days prior to the requested Effective Date, and no later than 15 days after the Effective Date of the Policy. This Disclosure Statement will become a part of the Application/Schedule for coverage.

NOTE: The Applicant/Policyholder is required to contact their claims administrator and utilization review firm(s) to obtain the requested information.

All information disclosed on this Disclosure Statement will be treated as confidential by AFAC. The Applicant/Policyholder named below, through its authorized officer, hereby represents that the information disclosed on page 2 of this form is true, complete, and accurate. If the Applicant/Policyholder fails to list any person who is required to be disclosed, and AFAC determines that such individual was an unacceptable risk that should have been disclosed, claims on such individual will be excluded from the Specific and/or Aggregate Excess Loss coverage provided by the Policy. The Applicant/Policyholder further acknowledges, understands, and agrees that this information may be used by AFAC in evaluating and determining the acceptability of this risk.

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

_____

Name of Applicant/Policyholder

_____ _____

Signature of Applicant/Policyholder's Authorized Representative — Date Signed

_____ _____

Authorized Representative's Name (type or print) — Authorized Representative's Title (type or print)

Name	*Status**	*Date of Birth*	*Date Disabled and/or Confined*	*Diagnosis and/or Nature of Disability*	*Prognosis and/or Estimate of Future Claims*	*Amount of Incurred Claims*

Please attach separate pages if additional space is needed.

**Status: E = Employee D = Dependent R = Retirees C = COBRA, FMLA, or other continuee*