QBE INSURANCE CORPORATION
Administrative Address:
Wall Street Plaza
88 Pine Street, 16th Floor
New York, NY 10005

APPLICATION FOR EXCESS POLICY

1. Full legal name of Policyholder : Tax id number:

   City of La Crosse **39-6005490**
   (as it will appear in the Policy)

2. Principal Office Address:

400 La Crosse Street	**La Crosse**	**WI**	**54601**
(street)	(city)	(state)	(zip)

3. Contact Person:_____

4. Nature of Business: **9199** **General Government, NEC**

5. If Employee Welfare Benefit Plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal names and addresses of such companies and the nature of their business:

   _____

   _____

   _____

6. Full name of YOUR Employee Welfare Benefit Plan:

   _____

   A copy of YOUR ERISA Employee Welfare Benefit Plan Document, and those of any subsidiary or affiliated companies that are to be included, must be attached to, and shall form a part of, this Application. If YOUR Employee Welfare Benefit Plan is for a MEWA (Multiple Employer Welfare Agreement) or an MET (Multiple Employer Trust), YOUR Application will not be accepted for consideration unless YOU provide a clear and concise statement from the U.S. Department of Labor that it is exempt from ERISA requirements.

7. Requested Effective Date: **01/01/2015**

8. Requested Endorsements: **Wisconsin Endorsement QBSL-0130 (09-02)**

9. OUR Underwriting Manager: **QBE A&H**

10. YOUR Designated Third–Party Administrator (for purpose of claims administration under YOUR Employee Welfare Benefit Plan):

    Name: **Benefit Plan Administrators of Eau Claire, Inc.**
    Address: **402 Graham Avenue 3rd Floor**
    City, State, Zip: **Eau Claire WI, 54702-1128**
    Telephone: **(715)832-5535**

QBE INS CORPORATION

Name: **Gundersen Lutheran Health Plan**
Address: **1836 South Ave., NCA2-01**
City, State, Zip: **La Crosse WI, 54601-5494**
Telephone: **(800)897-1923**

11. YOUR broker/agent of record:

Name: **The Horton Group., HCSC Benefit Division**
Address: **N19 W 24101 N. Riverwood Drive**
City, State, Zip: **Waukesha WI, 53188**
Telephone: **(262)347-2600**

12. **COVERAGES REQUESTED**

The Coverage shown applies only during the Policy Period from **01/01/2015** (Effective Date) Through **12/31/2015** (Expiration Date) and is further subject to all the provisions of the Policy.

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

1) Coverage to be included:

Yes	No	
☒	☐	Medical
☒	☐	Prescription Drugs
☐	☒	Dental
☐	☒	Vision

2) Specific Attachment Point (unless adjusted by Endorsement)
☒ Per Covered Person: **$ 100,000**
☐ Per Covered Family: **$ 0.00**
☒ Aggregating Specific Deductible: **$ 100,000**

3) Specific Reimbursement Percentage: **100%**

4) Specific Policy Period Maximum Reimbursement per Covered Person: **Unlimited upon satisfaction of specific deductible.**
☒ Of this amount, reimbursement for treatment of drug or alcohol abuse will be limited to:
☒ **The terms, conditions and limits as stated in the accepted plan document.**
☐ _____ days
☐ _____ days, up to $_____
☐ Treatment of drug or alcohol abuse considered as any other illness

5) Basis of Specific Excess Loss coverage benefit payment (Benefit Period):
Plan Benefits Incurred from: **01/01/2015** through: **12/31/2015**

And paid from: **01/01/2015** through: **03/31/2016**

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
☐ **N/A** per Covered Person
☐ **N/A** for all Covered Persons combined:

6) Premium Rates (per month):

Covered Unit Description		Amount	Covered Unit Description	Amount
Single	**149**	**$ 63.29**		
Family	**468**	**$ 140.56**		
Total	**617**			

7) Minimum Annual Specific Premium: **N/A. Estimated specific annual premium based on quoted enrollment is: $ 902,547.00.**

B. AGGREGATE EXCESS LOSS INSURANCE ☐ Yes, included ☒ No, not included

1) Coverage to be included:

Yes	No	
☐	☒	Medical
☐	☒	Dental
☐	☒	Vision
☐	☒	Prescription Drugs
☐	☒	Weekly Disability Income Maximum _____, per covered employee per Policy Period
☐	☒	Other:

2) Monthly Aggregate Factor:

Covered Unit Description	Medical	Dental	Vision	Prescription Drugs	Weekly Disability Income	Other	Total
Single:							**$ 0.00**
Family:							**$ 0.00**

3) Number of Covered Units: ☒ Quoted ☐ Actual

Covered Unit Description	Medical	Dental	Vision	Prescription Drugs	Weekly Disability Income
Composite:	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

4) Minimum Annual Aggregate Attachment Point: **$ 0 (Estimated)**
(12 times Monthly Aggregate Factor(s), times total Number of Covered Units)

5) Aggregate Reimbursement Percentage: **0%**

6) Individual Claim Limit: **$ 0**

7) Maximum Aggregate Reimbursement (per Policy Period): **$ 0**

8) Basis of Aggregate Excess Loss coverage benefit payment (Benefit Period):
Plan Benefits Incurred from: **N/A** through: **N/A**

And paid from: **N/A** through: **N/A**

Plan Benefits Incurred prior to the Effective Date (Run-In-Period) will be limited to:
☐ **N/A** per Covered Person
☐ **N/A** per all Covered Persons combined

9) Premium Rates (per month):

Covered Unit Description	Amount	Covered Unit Description	Amount
N/A	**$ 0**		

10) Minimum Annual Aggregate Premium: **N/A. Estimated annual aggregate premium based on quoted enrollment is: $ 0.**

13. Eligible for coverage:

Yes*	No	
☒	☐	Retired Employees
☒	☐	COBRA Continuee
☒	☐	Disabled Persons
☒	☐	Employees who are not Actively at Work
☐	☒	Late Entrants
☒	☐	Transplants
☐	☒	Other:

***All "Yes" answers must have disclosure information attached to this Application.**

14. Additional Information

a. Policy Information:

1. Your PPO is: **Gundersen Lutheran, Health Traditions, Health EOS.**

2. Your Utilization Review Provider is: **Gundersen Lutheran, Health Traditions.**

3. The definition of Specific Lifetime Maximum Reimbursement in the *Definitions* Section of this Policy, is deleted and replaced with:

Specific Policy Period Maximum Reimbursement means the maximum amount WE will reimburse YOU with respect to any Covered Person under this Policy during the Policy Period shown in the *Schedule*. The Policy Period Maximum excludes the Specific Attachment Point amount. The Policy Period Maximum will not exceed the lesser of:

1. the amount shown in the Schedule; and
2. the maximum benefit amount set forth in the Plan.

4. Section II, *Specific Excess Loss Coverage,* is deleted and replaced with the following:

Section II, SPECIFIC EXCESS LOSS COVERAGE

WE will reimburse YOU for Plan Benefits Paid in excess of the Specific Attachment Point, not to exceed the Policy Period Maximum Reimbursement amount shown in the Schedule. WE will reimburse YOU after YOU have provided an acceptable proof of loss and satisfactory proof of Paid Plan Benefits.

The Specific Excess Loss benefit applies to a Policy Period or fraction thereof (due to termination). As determined with regard to each Covered Person, it is the lesser of:

1. the Policy Period Maximum Benefit; and
2. eligible Plan Benefit Payments made with regard to a Covered Person, less the Specific Attachment Point, the result of which is then multiplied by the Specific Reimbursement Percentage.

In addition, the Specific Excess Loss Benefits Payable under this Policy will be reduced by the Aggregating Specific Deductible.

b. Special Limitations [redacted] **has an Alternative Specific Attachment Point of $575,000.**

Eligible claims incurred would apply to both the lasered specific deductibles and toward the satisfaction of the aggregating specific (or corridor if split funded), prior to potential reimbursement.

15. Initial premium deposit accompanying the application:
(Specific) $ **75,212.00.**

16. Minimum Plan Enrollment: **N/A** Covered Units, or **75** % of initial enrollment

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 the Application. YOU represent that YOU have formed YOUR Employee Welfare Benefit Plan in compliance with and in reliance on the applicable provisions of the Employee Retirement Income Security Act of 1974 (ERISA), as amended, or any other applicable law or regulation. It is agreed that the statements in the Application or in any materials submitted with this Application or attached to it 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 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. Any revision to the Policy or termination of the Policy is subject to the Time Limit on Certain Defenses provision.

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

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.

QBE INS CORPORATION

ACCEPTED BY THE POLICYHOLDER:

Signed at La Crosse, WI
City, State

Date 06/25/2015

City of La Crosse
Policyholder (correct legal name)

TIMOTHY KABAT MAYOR
By (Officer's name and title)

Timothy Kabat
Signature of Policyholder's Broker/Agent of Record

Barbara Bandry
Print Broker/Agent of Record

ACCEPTED BY THE COMPANY:

Signed at **Marblehead, Massachusetts**

Date **November 24, 2014**

On behalf of the Company
QBE Insurance Corporation

Steven L. Gransbury
Chief Operating Officer - Specialty
QBE North America
By (Officer's name and title)