DISCLOSURE STATEMENT

Account Name: _____ **Policy Term:** _____

Please provide the following information for all covered members:

1) Any member who has incurred and/or paid claims in excess of 50% of the deductible in the past 12 months, and/or
2) Any member who could be expected to exceed the deductible during the policy term:

Member Last Name, First	Member #	DOB	Type*	Provider Name : IN/OON*	Amount Paid	Amount Pending	Diagnosis	Prognosis

***KEY**
IN= Care Rendered by In Network Providers
OON= Care Rendered by Out of Network Providers
Type= Member Type. Please choose one of the following: Commercial, Medicare, Medicaid

After diligent review, the undersigned represents that the above information is complete and accurate to the best of his or her knowledge and belief.
Diligent Review, as it applies here, shall include a thorough and complete review of all current records maintained by all appropriate parties.

Authorized Representative _____ Name and Title (please print) _____ Date _____