APPLICATION TO
COMPANION LIFE INSURANCE COMPANY
COLUMBIA, SC 29223
FOR
AGGREGATE AND SPECIFIC EXCESS LOSS INSURANCE

Application is hereby made to the Companion Life Insurance Company ("Company") for Excess Loss Insurance. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant: **City of Sparks**

2. Address: **431 Prater Way**

   City: **Sparks** State: **NV** Zip Code: **89431**

3. If employee benefit plans of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies. **N/A**

4. Enter the full name of your Employee Benefit Plan(s) - (A copy of such Employee Benefit Plan(s) must be attached.) **City of Sparks Employee Benefits Plan**

5. Name and address of Designated Third Party Administrator:

   Hometown Health
   830 Harvard Way
   Reno, NV 89502

   Name of Primary Preferred Provider Organization: **Hometown Health**
   Contact: **Sandra Egoscue** Address: **830 Harvard Way ~ Reno, NV 89502**
   Phone: **775-982-3289** Fax: **775-982-3751**

   Name of Utilization Review Vendor: **Hometown Health**
   Contact: **Sandra Egoscue** Address: **830 Harvard Way ~ Reno, NV 89502**
   Phone: **775-982-3289** Fax: **775-982-3751**

6. Effective Date: **July 1, 2017**

7. Estimated Initial Enrollment (will be used as the Number of Covered Units during the first Contract Month):

   193 Singles and **461** Families

8. **GENERAL SCHEDULE OPTIONS:**

   (a) Disabled Persons **x** are [ ] are not covered.
   Retired Employees **x** are [ ] are not covered.

   (b) Aggregate Benefit [ ] Yes **x** No

   Aggregate Contract Basis: Employee Benefit Plan Expenses must be Incurred from **N/A** through **N/A** and
   Paid from **N/A** through **N/A**.

   Claims Incurred prior to the Contract Effective Date are limited to **N/A**

8. **GENERAL SCHEDULE OPTIONS**: (Continued)

Aggregate eligible expenses include:

[ ] Medical	[ ] Prescription Card Service
[ ] Dental Care	[ ] Weekly (Disability) Income
[ ] Vision Care	[ ] Other

Aggregate Monthly Factor per single Employee:	**N/A**
Family:	**N/A**
Aggregate Payable Percentage (excess of Deductible):	**N/A**
Maximum Eligible Claim Expense Per Covered Person:	**N/A**
Minimum Aggregate Deductible:	**N/A**
Maximum Aggregate Benefit (excess of Deductible):	**N/A**

(c) Monthly Aggregate Accommodation [ ] Yes **x** No

(d) Terminal Liability [ ] Yes **x** No

(e) Specific Benefit **x** Yes [ ] No

Specific Contract Basis: Employee Benefit Plan expenses must be Incurred from **July 1, 2016** through **June 30, 2018** and Paid from **July 1, 2017** through **June 30, 2018**

Claims Incurred prior to the Contract Effective Date are limited to: **N/A**

Specific Eligible Expense:

x Medical	**x** Prescription Card Service
[ ] Dental Care	[ ] Weekly (Disability) Income
[ ] Vision Care	[ ] Other

Specific Deductible (per person):	**$275,000**
Aggregating Specific Deductible:	**N/A**
Specific Payable Percentage (excess of Deductible):	**100%**
Maximum Specific Benefit (per person in excess of Specific Deductible):	**Unlimited**

9. **PREMIUMS:**

(a) Aggregate Premium

Premium Per Month Per Unit:	**N/A**
Minimum Annual Aggregate Premium	**N/A**
Monthly Aggregate Accommodation	
Premium Per Month Per Unit:	**N/A**
Annual Premium in Advance:	**N/A**
Terminal Liability	
Premium Per Month Per Unit:	**N/A**
Annual Premium in Advance:	**N/A**

(b) Specific Premium

Premium Per Month Per Single Employee:	**$26.24**
Family:	**$64.52**
Minimum Monthly Specific Premium:	**N/A**

Rate Stabilization: [ ] Yes **x** No

10. **SPECIAL RISK LIMITATIONS:**

Contract will be based upon the current employee benefits as defined in the Employee Benefit Plan by reference or by attachment, except as noted below:

Specific: **N/A**

Aggregate: **N/A**

11. **IT IS UNDERSTOOD AND AGREED, AS CONDITIONS PRECEDENT TO THE APPROVAL OF THIS APPLICATION, THAT:**

(a) All documentation requested by the Company must be submitted prior to any approval of this Application and must be received by the Company within ninety (90) days of the requested Effective Date.

(b) If the Schedule shows disabled persons are not covered, no benefits will be paid under the Contract for expenses Incurred or Paid under the Employee Benefit Plan for a disabled person until:

(1) if an employee, he or she returns to active, full-time employment for at least one (1) full working day; or

(2) if a dependent or Continuation Beneficiary, he or she is able to perform the normal functions of a person of like sex and age.

(c) Issuance of the Contract is in reliance upon the information provided by the Applicant or its Agent. Should subsequent information become known which, if known prior to issuance of the Contract, would have affected the rates, deductibles, terms or conditions for coverage, the Company will have the right to revise the rates, deductibles, terms or conditions as of the Effective Date of issuance, by providing written notice to the Insured.

(d) The Contract, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

(e) Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that Companion Life Insurance Company disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

(f) If a Contract is issued and later rescinded, the sum of all benefits paid will be deducted from the sum of all premiums paid. If the result is positive, such amount will be paid by the Company to the Applicant. If the result is negative, such amount will be paid by the Applicant to the Company.

(g) The initial premium will be paid on or before the Effective Date, and subsequent premiums are due no later than the first day of each calendar month during the Contract Period.

(h) Applicant acknowledges that the Contract which is the subject of this Application is a reimbursement Contract. Applicant must first pay claims before submitting them for reimbursement.

(I) Oral Statements not expressly incorporated herein are not part of this Contract. Only the President or Executive Officer of the Company may make changes to the Contract Form or Addenda on behalf of the Company. All changes to this Contract must be in writing and attached to this Contract.

(j) NEITHER THIS APPLICATION NOR THE TERMS OF THIS APPLICATION MAY BE ALTERED.

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Dated at_____ this _____ day of_____, 20____.

Witness: _____
Signature of Licensed
Resident Agent

Applicant: **City of Sparks**

Tax ID #: **88-6000202**

By: _____
(Officer/Partner)

Title: _____

Licensed Resident Agent: **L/P Insurance Services, Inc.**

Address: **300 East 2nd Street, Suite 1300**

City: **Reno** State: **NV** Zip: **89501**

Social Security or Tax ID #: **27-3054238**

ACCEPTANCE

Accepted on behalf of the Company, this _____ day of _____, 20____.

By: _____

Title: _____

Contract No.: _____ Effective Date: _____