FORSYTH COUNTY
BOARD OF COMMISSIONERS

REVISED ITEM

MEETING DATE: OCTOBER 26, 2015 **AGENDA ITEM NUMBER:** 7

SUBJECT: **RESOLUTION AWARDING A CONTRACT AND AUTHORIZING EXECUTION OF AN AGREEMENT AND OTHER NECESSARY DOCUMENTS BETWEEN FORSYTH COUNTY AND HCC LIFE INSURANCE COMPANY FOR EMPLOYEE MEDICAL AND PRESCRIPTION BENEFIT PLAN STOP LOSS INSURANCE COVERAGE (HUMAN RESOURCES DEPARTMENT)**

COUNTY MANAGER'S RECOMMENDATION OR COMMENTS: Recommend Approval

SUMMARY OF INFORMATION:

See attached

ATTACHMENTS: [X] YES [ ] NO

SIGNATURE: J. Dudley Watts, Jr. /bh
COUNTY MANAGER

DATE: October 21, 2015

RESOLUTION AWARDING A CONTRACT AND AUTHORIZING EXECUTION OF AN AGREEMENT AND OTHER NECESSARY DOCUMENTS BETWEEN FORSYTH COUNTY AND HCC LIFE INSURANCE COMPANY FOR EMPLOYEE MEDICAL AND PRESCRIPTION BENEFIT PLAN STOP LOSS INSURANCE COVERAGE (HUMAN RESOURCES DEPARTMENT)

WHEREAS, Forsyth County obtained bids for the provision of Employee Medical and Prescription Benefit Plan Stop Loss Insurance Coverage for the period, June 15, 2014 through June 30, 2016 and the following bids were received:

HCC Life Insurance Company	$35.23
Optum	$35.56
Sunlife	$47.84
ING	$51.80
Guardian	$81.49

; and

WHEREAS, HCC Life Insurance Company submitted the lowest bid at $35.23 per person; and

WHEREAS, it is the recommendation of the Chief Financial Officer, the Human Resources Department Director, and the County Manager that a contract be awarded to HCC Life Insurance Company for the provision of Employee Medical and Prescription Benefit Plan Stop Loss Insurance Coverage for the period, June 15, 2014 through June 30, 2016, in an annual amount not to exceed $897,096.72;

NOW, THEREFORE, BE IT RESOLVED that the Forsyth County Board of Commissioners hereby awards a contract to HCC Life Insurance Company, a subsidiary of HCC Insurance Holdings, Inc., for the provision of Employee Medical and Prescription Benefit Plan Stop Loss Insurance Coverage for the period, June 15, 2014 through June 30, 2016, in an annual amount not to exceed $897,096.72.

BE IT FURTHER RESOLVED that the Forsyth County Board of Commissioners hereby authorizes the County Manager and the Clerk to the Board to execute, on behalf of Forsyth County, an agreement and other necessary documents with HCC Life Insurance Company for the provision of Employee Medical and Prescription Benefit Plan Stop Loss Insurance Coverage for the period, June 15, 2014 through June 30, 2016, in an annual amount not to exceed $897,096.72, subject to a pre-audit certificate thereon by the County Chief Financial Officer, where applicable, and approval as to form and legality by the County Attorney.

BE IT FURTHER RESOLVED by the Forsyth County Board of Commissioners that the County Manager is hereby authorized to execute, on behalf of Forsyth County, subsequent contracts or contract amendments with this Provider for these services within budgeted appropriations in current and future fiscal years if these services are deemed necessary.

Adopted this 26th day of October 2015.

HCC Life Insurance Company
225 TownPark Drive, Suite 350, Kennesaw, Georgia 30144
main 770 973 9851 facsimile 770 973 9854

May 20, 2015

Tracy McCarty
Mark III Brokerage, Inc.
211 Greenwich Road
Charlotte, NC 28211

RE: Forsyth County Government
Effective Date: 07/01/2015

Dear Tracy,

Thank you for placing Forsyth County Government with HCC Life Insurance Company. It is our mission to provide you with superior products and service and to exceed your expectations in every aspect of the administration of this account. Our objective is to have your stop loss policy issued as soon as possible from the effective date of coverage.

Enclosed with this letter, are several items that must be executed and returned to us in order for the policy to be issued. This letter will serve as instructional guidance for each of the enclosed forms.

The forms are as follows:

(a) Application – Please have the application initialed and signed on the appropriate pages. On the last page of the Application, the "Dated At" portion should also be completed along with printing the name of the Officer/Partner as indicated. Any handwritten changes must be initialed by the Officer/Partner. Please be aware that the application is attached to and made a part of the policy. Please note the Licensed Agent signature must be the Licensed Agent who is (or will be) appointed with HCC Life Insurance Company as the representative of the Agent of Record listed on Page 1 of the Application. Also, please print the name of the Licensed Agent.

(b) Endorsements/Addendums – If Applicable, please have the endorsement(s) signed by both the Officer/Partner and the Licensed Agent, printing name(s) as indicated. Please refer to the above paragraph regarding the Licensed Agent.

(c) Business Associate Agreement – Our latest version of the agreement, which is designed to dovetail with the provisions of our Stop Loss policy, now contains all of the new required elements for HCC Life to fulfill its business associate responsibilities. All policyholders are requested to sign this revised agreement.

(d) Premium Accounting Worksheet – This is a self billing policy and as such the premium accounting worksheet, or similar form of conveyance, should be completed by the plan sponsor or their designee and forwarded to our attention each month with the appropriate premium payment. The Premium Accounting Worksheet included is for the first month's premium based on the enrollment provided on the underwriting proposal. The premium binder check, or first month's premium submission, should be made payable to HCC Life Insurance Company and mailed to

Regular Mail
HCC Life Insurance Company
P.O. Box 402032
Atlanta, GA 30384-2032

Overnight Mail
HCC Life Insurance Company
6000 Feldwood Road
Attention: Box 402032
College Park, GA 30349

All subsequent payments during the policy year should be mailed to the same address.

(e) Underwriting Requirements – Please note that the underwriter may have required additional reports or forms, such as a Disclosure Statement or updated claims information. This information must be received and approved prior to us releasing the Stop Loss Policy. Should you have any outstanding underwriting requirements please submit them to our attention for review and approval as soon as possible.

Please return all completed documentation to my attention at:

HCC Life Insurance Company
225 TownPark Drive, Suite 350
Kennesaw, GA 30144

HCC Life Insurance Company is rated A+ (Superior) by *A.M. Best Company* and is backed by the financial resources and commitment of our parent company, HCC Insurance Holdings, Inc. For more information about our company, our products and our locations, please visit our website, www.hcclife.com.

Should you have any questions, or if I can be of any assistance, please contact me.

Sincerely,

Jackie Burress
Underwriting Assistant III

HCC LIFE INSURANCE COMPANY

Group Name: Forsyth County Government

Effective Date: 07/01/2015

Items Due

☐	50% Report/Shock Loss Report - 7/1/14 - 6/30/15	Due Date: 07/15/2015
☐	Stop Loss Application	Due Date: 07/15/2015
☐	Binder Premium	Due Date: 07/15/2015
☐	Business Associate Agreement Form	Due Date: 07/15/2015
☐	Employee Benefit Plan (plandocs@hcclife.com)	Due Date: 07/15/2015

STOP LOSS INSURANCE
HCC LIFE INSURANCE COMPANY
Three Town Park Commons, 225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144 (800 447-0460)
APPLICATION

1. Full Legal Name of Applicant and Address
Forsyth County Government
201 N. Chestnut Street
Winston Salem, NC 27101
Telephone No.:

2. Applicant is a (check one):
☐ Corporation ☐ Labor Union ☐ Trust
☐ Association ☐ PEO
☐ Partnership ☐ MEWA
Other: **Unknown**

3. Contract Period: **Effective Date: 07/01/2015** **Expiration Date: 06/30/2016**

4. Full Legal Name of Affiliates, Subsidiaries and other major locations to be included in coverage:

Address of Affiliates or Subsidiaries: ☐ None ☐ See attached listing

5. Nature of Business of the Applicant to be Insured:
Government

6. Key Contact Person at Applicant:

7. Enter full name of the Employee Benefit Plan(s): **Forsyth County Government**
A signed copy of such Employee Benefit Plan(s) must be attached and will form part of this contract.

8. Name and Address of Plan Supervisor:
Blue Cross Blue Shield of North Carolina P.O. Box 580017 Charlotte, NC 28258

9. Agent of Record: **Mark III Brokerage, Inc.**

10. Estimated Initial Enrollment: **Composite: 2,122 Total Covered Units: 2,122**

11. Retirees Covered: ☒ Yes ☐ No

12. The Utilization Review vendor will be: **Blue Cross/Blue Shield of North Carolina**

13. Deposit Premium (Minimum of first month's estimated premium): **$ 74,758.06**
Please review the deposit premium on the Monthly Premium Accounting Worksheet.

14. **SPECIFIC STOP LOSS INSURANCE:** ☒ Yes ☐ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Specific Stop Loss Insurance (not included unless checked):
☒ Medical ☒ Prescription Drug Card ☐ Prescription Drugs Under Medical ☐ Other:

B. Specific Deductible in each Contract Period per Covered Person: **$175,000**

C. Contract Basis: **24/12**
Covered Expenses Incurred from 07/01/2014 through 06/30/2016, and Paid from 07/01/2015 through 06/30/2016.

D. Unlimited Specific Lifetime Reimbursement Maximum per Covered Person
Specific Contract Period Reimbursement Maximum per Covered Person **$1,075,000**

E. Separate Individual Specific Deductible: **None**

F. Monthly Specific Premium Rates:
Composite: $35.23

G. Specific Percentage Reimbursable **100%**

H. Specific Terminal Liability Option: ☐ Yes ☒ No
Specific Terminal Liability Option premium per Covered Person per month:

15. **AGGREGATE STOP LOSS INSURANCE:** ☐ Yes ☒ No

A. Covered Expenses Paid under the Employee Benefit Plan for the following Plan Benefits are covered for Aggregate Stop Loss Insurance (not included unless checked):
☐ Medical ☐ Dental ☐ Weekly Income ☐ Vision ☐ Prescription Drug Card ☐ Prescription Drugs under Medical ☐ Other:

B. Minimum Annual Aggregate Deductible: $
(Subject to the Definition of Minimum Annual Aggregate Deductible in the Policy)

C. Contract Basis:

D. Aggregate Contract Period Reimbursement Maximum: $

E. Monthly Aggregate Factors:

Monthly Factors	Combined	Medical	Dental	Weekly Income	Vision	Prescription Drugs
Single						
Employee + Child						

F. Aggregate Percentage Reimbursable %

G. Loss Limit: $
For the purposes of Aggregate Stop Loss Insurance, the Loss Limit is the maximum amount of Covered Expenses Incurred by each Covered Person, which can be used to satisfy the Annual Aggregate Deductible.

H. Monthly Deductible Advance Reimbursement Option: ☐ Yes ☐ No

I. Aggregate Terminal Liability Option: ☐ Yes ☐ No

J. Aggregate Premium:
1. ☐ Annual Premium payable in advance for Contract Period:
2. ☐ Monthly Premium rate per Covered Unit:
3. ☐ Monthly Deductible Advance Reimbursement premium per Covered Unit per month:
4. ☐ Aggregate Terminal Liability Option premium per Covered Unit per month:

SPECIAL RISK LIMITATIONS are stated on the Addendum to Application (if applicable).

It is understood and agreed by the Applicant that:

1. The Applicant is financially sound, with sufficient capital and cash flow to accept the risks inherent in a "self-funded" health care plan, and
2. The Plan Supervisor retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent, and
3. All documentation requested by the Company must be received within 90 days of the Policy effective date, and is subject to approval by the Company and may require adjustment of rates, factors, and / or Special Limitations to accommodate for abnormal risks, and
4. The Stop Loss Insurance applied for herein will not become effective until accepted by the Company, and
5. Premiums are not considered paid until the premium check is received by the Company, is paid according to the rates set forth in the Application, and all items required to issue the Policy have been returned to the Company. Premiums are subject to refund should any outstanding policy requirement not be met within 90 days of the Policy's effective date, and
6. This Application will be attached to and made a part of the Policy issued by the Company, and
7. The Employee Benefit Plan(s) attached shall be the basis of any Stop Loss Insurance provided by the Company and such Employee Benefit Plan(s) conforms with all applicable State and Federal statutes, and
8. Any reimbursement under the Stop Loss Insurance provided by the Company shall be based on Covered Expenses Paid by the Applicant in accordance with the Employee Benefit Plan(s) attached hereto, and
9. After diligent and complete review, the representations made in this Application, the disclosures made, and all of the information provided for underwriters to evaluate the risk, are true and complete.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

Full Legal Name of Applicant: Applicant's Federal Tax I.D. Number:

Forsyth County Government **566000450**

Dated at _____ this _____ day of _____, 20____.

_____ _____

Officer / Partner Signature (print name) Licensed Agent Signature (print name)

For HCC Life Insurance Company Office Use Only: ACCEPTANCE

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

By:_____ Title: _____

Policy No.: _____

This instrument has been preaudited in the manner required by the Local Government Budget and Fiscal Control Act.

10/5/2015 Paul I. Fr...

Date **Director of Finance**

BUSINESS ASSOCIATE AGREEMENT FORM

Part I - Preamble

A. **Effective Date:** The effective date of this Business Associate Agreement ("Agreement") is 07/01/2015.

B. **Parties:** The parties to this Agreement are Forsyth County Government, ("Covered Entity"), and HCC Life Insurance Company ("HCC Life" and "Business Associate"), an Indiana corporation. HCC Life is a stop loss insurance carrier and all references in this agreement to "stop loss insurance carrier" refer to HCC Life. For purposes of this Agreement, HCC Life is a business associate (as defined in the HIPAA Rules as defined below) of Covered Entity. Covered Entity and Business Associate agree that there shall be no third party beneficiaries to this Agreement, including but not limited to individuals whose Protected Health Information (defined below) is created, received, used, and/or disclosed by Business Associate in its role as business associate.

C. **Purpose:** The parties intend that this Agreement comply with the business associate agreement requirements set forth in HIPAA Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164, Subparts A and E, ("Privacy Standards"), the HIPAA Security Standards,45 C.F.R. Part 160 and Part 164, Subparts A and C ("Security Standards"), and the HIPAA Breach Notification Rule3, 45 C.F.R. Part 160 and Part 164, Subparts A and D ("Breach Notification Rule"), as amended from time to time (collectively, the "HIPAA Rules").

D. In connection with the Business Associate's creation, receipt, use, and/or disclosure of Protected Health Information, the parties agree as follows.

Part II - General Terminology

A. The following terms shall have the same meaning in this Agreement as is set forth in the HIPAA Rules: breach, data aggregation, designated record set, individual, required by law, Secretary, security incident and unsecured protected health information. Protected Health Information ("PHI") shall have the same meaning as the term "protected health information" in 45 C.F.R. § 160.103, but limited to the information created or received by Business Associate from, or on behalf of, Covered Entity.

B. In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Rules, as may be expressly amended from time to time by the U.S. Department of Health and Human Services ("HHS") or as a result of interpretations by HHS, a court, or another regulatory agency with authority over the parties, the interpretation of HHS, such court, or regulatory agency shall prevail. In the event of a conflict among the interpretations of these entities, the conflict shall be resolved in accordance with rules of precedence.

C. Where there are provisions in this Agreement additional to those mandated by the HIPAA Rules, but which are not prohibited by the HIPAA Rules, the provisions of this Agreement will apply.

Part III – Permitted Uses and Disclosures by Business Associate

A. Except as otherwise provided in this Agreement, Business Associate may receive, use, disclose or maintain PHI on behalf of, or to provide services to, Covered Entity for the following purposes, if such use or disclosure of PHI would not violate the HIPAA Rules if done by Covered Entity: (1) those functions, activities, and/or services as are identified in the Stop Loss Policy between the Covered Entity and the Business Associate and/or (2) those functions, activities, and/or services provided by Business Associate in connection with application and underwriting processes.

B. As part of its providing functions, activities, and/or services to Covered Entity as identified in Part III.A., Business Associate may disclose information, including PHI, to other business associates of Covered Entity and may use and disclose information, including PHI, received from other business associates of Covered Entity as if this information was received from, or originated with, Covered Entity.

C. Business Associate agrees not to use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

D. Business Associate agrees to use appropriate safeguards to prevent the use or disclosure of PHI other than as provided for by this Agreement or as required by law. Business Associate will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Covered Entity.

E. Except as otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate.

F. Except as otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of Business Associate, provided that disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

G. Except as otherwise limited in this Agreement, Business Associate may use PHI to provide data aggregation services to Covered Entity as permitted by the HIPAA Rules.

H. Business Associate agrees that it will enter into a written agreement with all subcontractors of Business Associate that: (i) applies the same restrictions and conditions of this Agreement to the subcontractor's disclosure, receipt, maintenance, transmission or use of PHI; (ii) complies with the terms of the HIPAA Rules; (iii) requires the subcontractor to notify Business Associate, who shall in turn promptly notify Covered Entity, of any security incident, breach or other impermissible use or disclosure of PHI that the subcontractor becomes aware of; and (iv) notifies such subcontractors that they will incur liability under the HIPAA Rules for non-compliance with such provisions.

I. If Business Associate becomes aware of any use or disclosure of PHI that is not provided for in this Agreement, Business Associate will report that use or disclosure to Covered Entity as soon as reasonably possible. If Business Associate becomes aware of any security incident concerning electronic PHI, Business Associate will report that incident to Covered Entity as soon as reasonably possible.

J. Business Associate agrees, at the written request of Covered Entity, to provide access to PHI in accordance with 45 C.F.R. § 164.524. Business Associate may require Covered Entity to pay certain fees, as delineated in 45 C.F.R. § 164.524(c)(4), for it to provide copies or summaries of PHI.

K. Upon receiving written notification from Covered Entity that it has directed or agreed, pursuant to 45 C.F.R. § 164.526, to amend PHI, Business Associate agrees to make PHI available for amendment and incorporate any such amendments to PHI as directed by Covered Entity.

L. In accordance with 45 C.F.R. § 164.528, Business Associate will retain and make available to Covered Entity, upon written request, the information required by Covered Entity to provide an accounting of disclosures, if so requested by an individual.

M. For the purpose of the Secretary determining Covered Entity's compliance with the HIPAA Rules, Business Associate shall make available to the Secretary the Business Associate's internal practices, books, and records relating to the use and disclosure of PHI. No attorney-client, accountant-client, or other legal privilege will be deemed to have been waived by Business Associate by virtue of this provision of the Agreement.

N. Business Associate agrees to, as soon as practicable, but in no case later than 30 calendar days after the discovery of a breach of unsecured protected health information, notify Covered Entity of such breach. A breach shall be treated as discovered as of the first day on which such breach is known, or by exercising reasonable diligence would have been known, to any person, other than the person committing the breach, who is an employee, officer or agent of Business Associate. The notification shall include, to the extent possible, the identification of each individual whose unsecured protected health information has been, or is reasonably believed by Business Associate to have been, accessed, acquired, used or disclosed during the breach. In addition, Business Associate shall provide Covered Entity with any other available information that Covered Entity is required to include in the notification to the individual under 45 C.F.R. § 164.404(c) of the HIPAA Rules.

O. Business Associate agrees to take commercially reasonable steps to mitigate, to the extent practicable, any harmful effect that is known to the Business Associate resulting from any unauthorized access, use, disclosure, modification or destruction of PHI.

P. Except as provided for by the stop loss policy, Business Associate will not directly or indirectly receive remuneration in exchange for any PHI of an individual.

Part IV - Obligations of Covered Entity

A. Upon request, Covered Entity shall provide, in a timely manner, Business Associate with the Notice of Privacy Practices that Covered Entity produces in accordance with 45 C.F.R. § 164.520, as well as any changes to such Notice.

B. Covered Entity shall provide Business Associate with any changes in, or revocation of, permissions by the Covered Entity or any individual to use or disclose PHI if such changes, revocations or permissions affect Business Associate's permitted or required uses and disclosures.

C. Covered Entity shall notify Business Associate, in writing and in a timely manner, of any restriction to the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 C.F.R. § 164.522 to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

D. Except for Business Associate's management and administrative activities and data aggregation, Covered Entity shall not request that Business Associate use or disclose PHI in any manner that would not be permissible under the HIPAA Rules if done by Covered Entity.

Part V - Termination Provisions

A. This Agreement shall continue until it is terminated by any of the parties or if a Stop Loss Policy exists between the Covered Entity and the stop loss insurance carrier, the Stop Loss Policy expires without renewal. Any party to this Agreement may terminate this Agreement without the necessity of showing cause by the delivery of a written notice from the terminating party to the other parties. However, if a Stop Loss Policy exists between the Covered Entity and the stop loss insurance carrier, then the termination of this Agreement shall not be effective until either (1) all claims under the Stop Loss Policy are received and processed by Business Associate or (2) the time period delineated in the Stop Loss Policy for claims to be submitted to Business Associate and processed by Business Associate upon the Policy's termination, has expired, whichever event occurs first. If no Stop Loss Policy exists between Covered Entity and the stop loss insurance carrier then the termination is effective ten (10) business days from the date that the party receives such notice. Notwithstanding any other provision of this Agreement, Covered Entity will not

withhold PHI from Business Associate so as to prevent Business Associate from using its usual and routine claims processing procedures to process claims under this section.

B. If Covered Entity determines that Business Associate has violated a material term of this Agreement then Covered Entity shall inform Business Associate in writing of the violation and Business Associate shall either terminate this Agreement under paragraph Part V.A. or endeavor to cure such violation. If Business Associate endeavors to cure the violation but fails to do so in a reasonable period of time, Covered Entity may terminate this Agreement upon written notice. Such termination shall be effective on the date that Business Associate receives the termination notice from Covered Entity which states that Covered Entity wishes to terminate this Agreement under this provision and states the material term of this Agreement that Covered Entity believes has been violated by Business Associate; however, any amounts due from Covered Entity to Business Associate as of the effective date of the termination continue to be so due.

C. Subject to the Part V.A. above, if a Stop Loss Policy exists between Covered Entity and the stop loss insurance carrier and such Stop Loss Policy is terminated or expires, this Agreement shall be deemed to have terminated at the same moment the Stop Loss Policy's termination or expiration became effective. Similarly, and subject to Part.V.A. above, if this Agreement is terminated by any party, all other agreements then existing between Business Associate and Covered Entity, unless otherwise agreed to in writing by Business Associate and Covered Entity, are also deemed to have been terminated at the same moment this Agreement's termination became effective. However, in either case, any amounts due from Covered Entity to Business Associate under any such agreements as of the effective date of termination continue to be due.

D. Upon the termination of this Agreement, Business Associate will, if feasible, return to Covered Entity all PHI or, at its discretion, in the alternative, Business Associate will destroy all PHI. If such return or destruction is not feasible, Business Associate will continue to extend the protections of this Agreement to the PHI and limit further uses and disclosures to those purposes that make the return or destruction of the PHI not feasible.

HCC Life Insurance Company	**Forsyth County Government**
By: _____	By: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____

Revised 06/13

HCC LIFE INSURANCE COMPANY

Policyholder **Forsyth County Government** Policy No. **HCL31777** Effective Date **07/01/2015**

Administrator **Blue Cross Blue Shield of North Carolina** Report Period **07/01/2015** to **07/31/2015**

Coverage	Current Units	Prior* Units	Total Units		Rates	Gross Premium
Specific						
Composite	2,122		2,122	X	**35.23**	74,758.06
				X		
				X		
				X		
			Gross Premium			74,758.06
Aggregate						
	0		0	X		0.00
				X		
				X		
				X		
			Gross Premium			0.00
MDAR						
				X	**ANNUAL**	0.00
Medical Conversion						
Gross Premium	0		0	X	**0.00**	0.00
			Gross Premium			0.00
State Assessment Fee	2,122		2,122	X	**0.0000**	0.00
Total Gross Premium						74,758.06

*Prior month adjustments are limited to the preceding 3 months. You must attach documentation to receive consideration for any other months.

Please make checks payable to **HCC LIFE INSURANCE COMPANY**. Send checks to: HCC Life Insurance Company, P.O. Box 402032, Atlanta, GA 30384-2032.

Prepared on 5/20/2015