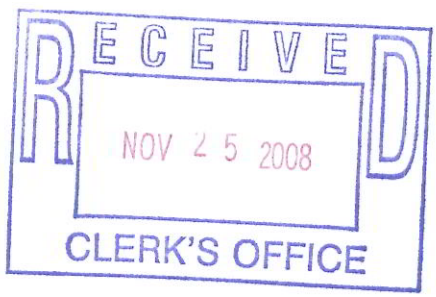
Clerk's Contract and Agreement Cover Page

Year:	2009	**Legistar File ID#:**	2008-0545
Multi Year:	☐	**Amount**	$68,750.00

Contract Type:	Professional Services
Contractor's Name:	Horton Group
Contractor's AKA:	
Execution Date:	10/1/2008
Termination Date:	12/31/2009
Renewal Date:	
Department:	Administration/Village Manager
Originating Person:	Stephana Przybylski

Contract Description: 2008-2009 Employee Insurance Renewal and Consulting
BCBS, VSP, Delta



BlueCross BlueShield of Illinois

BENEFIT PROGRAM APPLICATION ("BPA")

(Applicable to Unified 151-Plus Insured Group Accounts)
(All items are applicable to the HMO plan and the Non-HMO plan unless otherwise specified.)

Employer Account Number: 206338

HMO Illinois Employer Group Number(s): H06652

HMO Illinois Section Number(s): 0512,1510,2510,8510

BlueAdvantage® HMO Employer Group Number(s): _____

BlueAdvantage® HMO Section Number(s): _____

Non-HMO Plan Employer Group Number(s): P06652 - PPO P06870 - HSA - P07366 - HSA

Non-HMO Plan Section Number(s): 0812,1812,2812,8812

Employer Name: Village of Orland Park

(Specify the employer, the employee trust or the association applying for coverage. List subsidiary or affiliated companies to be covered below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

Address: 14700 Ravinia Avenue City: Orland Park State: Illinois Zip Code: 60462

Billing Address *(if different from above)* : _____ City: _____ State: _____ Zip Code: _____

Subsidiaries: _____

Affiliated Companies: _____

(If Affiliated Companies to be covered are listed above, a separate "Addendum to the Benefit Program Application Regarding Affiliated Companies" must be completed, signed by the Employer's authorized representative, and attached to this BPA.)

Administrative Contact: Stephana Przybylski Phone: 708-403-6166 Fax: 708-349-4859 Email: sprzybylski@orland-park.il.us

Policy Effective Date: October 1, 2008 Policy Anniversary Date: January 1, 2010

ERISA Plan: ☐ Yes ☒ No If Yes, specify ERISA Plan Year: _____

ERISA Plan Administrator: _____

ERISA Plan Administrator's Address: _____

City: _____ State: _____ Zip Code: _____

ERISA Plan Administrator's Email: _____

ELIGIBILITY

1. Eligible Person means: (For the HMO plan, an eligible person must reside in the Service Area of a Participating IPA)

   ☐ A full-time employee of the Employer.

   ☐ A full-time employee who is a member of: _____ (name of union or association)

   ☒ Other (please specify): Full - time employees; retirees and disabled police officers; retired and disabled members of IMRF; elected officials

   Full-Time Employee means:

   ☒ A person who is regularly scheduled to work a minimum of 40 hours per week and who is on the permanent payroll of the Employer.

   ☐ Other (please specify): _____

   ☐ An Eligible Person may also include a retiree of the Employer. Please specify: _____.

2. Domestic Partner Coverage: ☐ Yes ☒ No

   If yes, a Domestic Partner, as defined in the Policy, shall be considered eligible for coverage. The Policyholder is responsible for providing notice of possible tax implications to those Insureds with Domestic Partner coverage.

3. Limiting Age for covered unmarried children is unmarried to age 19; part time students to age 23 years; 25 years if a full-time student.

For Premium Funding, coverage will terminate at the end of the following period for which premium has been accepted:

For the Non-HMO Plan:

☐ On birthday.

☐ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached

For the HMO Plan:

☐ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached.

☐ Other (please specify): _____

For Cost Plus Funding, coverage will terminate at the end of the following period:

For the Non-HMO Plan:

☐ On birthday.

☒ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached

For the HMO Plan:

☒ The month in which the limiting age is reached.

☐ The year in which the limiting age is reached.

☐ Other (please specify): _____

4. Eligibility Date for a person who becomes an Eligible Person after the Effective Date of the Employer's health care plan:

☒ The date of employment.

☐ The _____ day of employment.

☐ The _____ day of the month following _____ month(s) or _____ days of employment.

☐ The _____ day of the month following the date of employment.

☐ Other (please specify): _____

☐ For the HMO plan: A full month's premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the first and fifteenth day of the Premium period. No premium will be charged for the first month of coverage for those employees whose Coverage Dates fall between the sixteenth day and the end of the Premium Period.

5. Special Enrollment: An Eligible Person may apply for coverage, Family coverage or add dependents within thirty-one (31) days of a Special Enrollment event if he/she did not apply prior to his/her Eligibility Date or when eligible to do so. Such person's Coverage Date, Family Coverage Date, and /or dependent's Coverage Date will be effective on the date of the Special Enrollment event or, in the event of Special Enrollment due to termination of previous coverage, the date of application for coverage.

Annual Open Enrollment: Specify Annual Open Enrollment Period:September 1 - 30 for an October 1 effective date.. An Eligible Person may apply for coverage, Family coverage or add dependents if he/she did not apply prior to his/her Eligibility Date or did not apply when eligible to do so, during the Employer's Annual Open Enrollment Period. Such person's Coverage Date, Family Coverage Date, and/or dependent's Coverage Date will be a date mutually agreed to

by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") and the Employer. Such date shall be subsequent to the annual open enrollment period.

6. Extension of benefits due to Temporary Layoff, Disability or Leave of Absence:

   Temporary Layoff: 0 days Disability: 0 days Leave of Absence: 0 days

   ☐ Other: (please specify): _____

   (However, benefits shall be extended for the duration of an Eligible Person's leave in accordance with any applicable federal or state law.)

7. For the HMO Plan:

   Total Number of Employees (Please indicate the total number of actual employees, not enrollees):

   Of the Employer: 350 Illinois employees: 350 National employees: 0

FUNDING ARRANGEMENT

☐ Standard Premium – Prospective ☒ Cost Plus Program

STANDARD PREMIUM INFORMATION:

(a) Premium Period:
- ☐ The first day of each calendar month through the last day of each calendar month.
- ☐ The _____ day of each calendar month through the _____ day of the next calendar month.
- ☐ Other (please specify): _____

(b) Employer contribution:

For the HMO Plan:
- ☐ HMO Illinois: _____% of the Individual Coverage Premium and _____% of Family Coverage Premium.
- ☐ BlueAdvantage® HMO: _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
- ☐ Other (please specify): _____

For the Non-HMO Plan:
- ☐ 100% of the Individual Coverage Premium and an amount equal to 100% of the Individual Coverage Premium will be contributed toward the Family Coverage Premium.
- ☐ _____% of the Individual Coverage Premium and _____% of the Family Coverage Premium.
- ☐ Other (please specify): _____

(c) For the Non-HMO Plan:
It is understood that no Policy will be issued or renewed on a contributory basis unless at least _____% of the Eligible Persons and, for Family Coverage, _____% of the Eligible Persons with eligible dependents have enrolled for coverage.

STANDARD PREMIUM RATES ☐ Yes ☒ No						
	For Internal Use Only - BlueStar Ben Agree#: _____ **HMO Illinois** _____	*For Internal Use Only - BlueStar Ben Agree#:* _____ **Blue Advantage® HMO** _____	*For Internal Use Only - BlueStar Ben Agree#:* _____ **Non-HMO Health Coverage:** _____	*For Internal Use Only - BlueStar Ben Agree#:* _____ **Non-HMO Health Coverage:** _____	*For Internal Use Only - BlueStar Ben Agree#:* _____ **Dental Coverage:** _____	**Total**
1. Employee only:	$	$	$	$	$	$
2. Employee plus one dependent:	$	$	$	$	$	$
3. Employee plus two or more dependents:	$	$	$	$	$	$
4. Employee plus Spouse:	$	$	$	$	$	$
5. Employee plus Child(ren):	$	$	$	$	$	$
6. Employee plus Family / Family:	$	$	$	$	$	$
7. Other: _____	$	$	$	$	$	$
Single Tier Rate structure - Complete item 1.						
Two Tier Rate structure - Complete items 1. and 6.						
Three Tier Rate structure - Complete items 1., 2., and 3.						
Four Tier Rate Structure - Complete items 1., 4., 5., and 6.						
Indicate "N/A" in any rate field that does not apply.						
Medicare Eligible Rates (When HCSC is Secondary Payer)						
Single Coverage:	$	$	$	$		$
Family Coverage:	$	$	$	$		$

COST PLUS PROGRAM

☒ Yes ☐ No

Service Charges:
For the HMO Plan:

a) Service Charges for Claim Payments:

☒ HMO Illinois: _____% of Claim Payments; or $55.44 per Enrollee per month for health Claim Payments
☐ BlueAdvantage® HMO: _____% of Claim Payments; or $_____ per Enrollee per month for health Claim Payments

b) Physician's Services Fees:

☒ HMO Illinois: $151.35 per month per single Enrollee; or $441.14 per Month per Enrollee with one or more dependents.
☐ BlueAdvantage® HMO: $_____ Per month per single Enrollee; or $_____ Per Month per Enrollee with one or more dependents.

For the Non-HMO Plan:

☒ _____% of Net Claim Payments or $55.44 per employee per month.
☒ Applies to all coverage(s)

☐ Different percentage(s) or amount(s) for the following types of coverage. Please specify below:
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month
For _____ Coverage: _____% of _____ Claim Payments or $_____ per employee per month
Other (please specify): _____

Blue Care Connection® ("BCC") (For the Non-HMO Plan):

BCC Program (may select one):
☒ Blue Care Advisor
☐ Please refer to Additional Provisions

☐ Fee: $_____ per covered employee per month for administration of the program.
☒ Fee is included in the Service Charges.

Blue Care Custom

☐ Health Dialog **(may select one)** Health Dialog Fee: $_____ per covered employee per month
- ☐ Health Coach Line (In bound)
- ☐ Health Coach Line (In and out bound)
- ☐ Health Coach Line (With Disease Management)
- ☐ Not applicable

☐ American Healthways **(may select one)**
- ☐ Package A
- ☐ Package B
- ☐ Package C
- ☐ Not applicable

American Healthways Program Fees, per participating Covered Person per month:

Conditions:	*Package A - Fees*	*Package B - Fees*	*Package C - Fees*
Diabetes:	$_____	$_____	$_____
Chronic Heart Disease:	$_____	$_____	$_____
Chronic Obstructive Pulmonary Disease	$_____	$_____	Not Applicable
Asthma:	$_____	$_____	Not Applicable
Impact Conditions:	$_____	Not Applicable	Not Applicable

Payment Method: ☐ Transfer Payment ☒ Post Payment

If Transfer Payment, Method of Transfer Payment:
☐ Wire Transfer ☐ Draft ☐ Electronic Fund Transfer ☐ Other (please specify):_____

Payment Period:
☐ Daily ☐ Weekly ☐ Bi-Weekly ☐ Monthly ☐ Other (please specify): _____

Claim Settlement Period: ☒ Monthly ☐ Quarterly ☐ Other (please specify): _____

If Transfer Payment, Tentative Final Settlement Period:
Transfer Payments to be made for the following time period after termination:
☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other (please specify): _____

For Cost Plus plans, Effective Date of Termination for a person who ceases to meet the definition of Eligible Person:

☐ The date such person ceases to meet the definition of Eligible Person.
☒ The last day of the calendar month in which such person ceases to meet the definition of an Eligible Person.
☐ Other (please specify): _____

Prescription Drug Rebate: $_____ per Covered Employee per month or, for the HMO Plan, per Enrollee per month is the guaranteed Prescription Drug Rebate savings reflected as a Prescription Drug Rebate credit.

FOR NON-HMO COST-PLUS PROGRAMS ONLY:
PLAN PROVIDER ACCESS FEE(S)
☒ **Yes** ☐ **No**

Group Number(s):

☒% of ADP Savings: 3.5%

☐ $ Per Employee per Month: $_____

Please complete for groups with multiple products (for example, Comprehensive Major Medical and PPO) with separate access fees:
Group Number(s): _____

☐% of ADP Savings: _____%

☐ $ Per Employee per Month: $_____

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Employer, has provided the information requested in this Benefit Program Application ("BPA") and, on behalf of the Employer, offers to purchase the benefit program as outlined in the Request For Proposal ("RFP") or, in the case of an HMO Plan, the proposal document submitted to the Employer by the Sales Representative. Any changes to the RFP are specified below. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Policy. This BPA is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Policy to the Employer and this BPA shall be incorporated and made a part of the Policy. Upon acceptance of this BPA and issuance of the Policy, the Employer shall be referred to as the Policyholder. In the event of any conflict between the RFP and the Policy, the provisions of the Policy shall prevail.

The undersigned representative acknowledges that any broker/producer is acting on behalf of the Employer for purposes of purchasing the Employer's insurance, and that if HCSC accepts this BPA and issues a Policy to the Employer, HCSC may pay the Employer's broker/producer a commission and/or other compensation in connection with the issuance of such Policy. The undersigned representative further acknowledges that if the Employer desires additional information regarding any commissions or other compensation paid the broker/producer by HCSC in connection with the issuance of a Policy, the Employer should contact its broker/producer.

The undersigned representative acknowledges that the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") establishes certain requirements for employee welfare benefit plans. As defined in Section 3 of ERISA, the term "employee welfare benefit plan" includes any plan, fund or program which is established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital benefits, or benefits in the event of sickness, accident or disability. The undersigned representative further acknowledges that: (i) an employee welfare benefit plan must be established and maintained through a separate plan document which may include the terms hereof or incorporate the terms hereof by reference, and that (ii) an employee welfare benefit plan document may provide for the allocation or delegation of responsibilities thereunder. However, notwithstanding anything contained in the employee welfare benefit plan document of the Employer (or any group member if the group is an association), the Employer agrees that no allocation or delegation of any fiduciary or nonfiduciary responsibilities under the employee welfare benefit plan of the Employer (or, for Non-HMO Plans, any group member if the group is an association) is effective with respect to or accepted by HCSC except to the extent specifically provided and accepted in this BPA or the Policy or otherwise accepted in writing by HCSC.

OTHER PROVISIONS:

(a) Reimbursement Provision for the HMO Plan: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will deduct 25% of the net recovery from the amount credited to the group's experience after attorneys' fees, if any, have been paid.

Reimbursement Provision for the Non-HMO Plan: ☒ Yes ☐ No

If yes: It is understood and agreed that in the event HCSC makes a recovery on a third-party liability claim, HCSC will retain 25% of the net recovery (under cost-plus funding) or deduct 25% of the net recovery from the amount credited to the group's experience (under premium funding) after attorneys' fees, if any, have been paid.

(b) Certificate of Creditable Coverage: ☒ Yes ☐ No

If yes: It is understood and agreed that HCSC will issue a Certificate of Creditable Coverage consistent with the requirements under the Health Insurance Portability and Accountability Act of 1996. The Certificate of Creditable Coverage shall be based upon coverage under the Plan during the term of the Policy and information provided to HCSC by the Employer.

If no: The Certificate of Creditable Coverage Release and Indemnification letter is attached to this BPA and made part of the Policy.

(c) BlueCare® Dental HMO Coverage purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(d) Fort Dearborn Life Insurance purchased: ☐ Yes ☒ No *(If yes, complete separate application.)*

(e) Excess Loss Coverage purchased: ☒ Yes ☐ No *(If yes, complete separate application.)*

(f) For the Non-HMO Plan:
Case Management: ☒ Yes ☐ No

If Yes: The undersigned representative authorizes provision of alternative benefits for services rendered to Covered Persons in accordance with the provisions of the Policy.

(g) For the Non-HMO Plan: Electronic Issuance: The Policyholder consents to receive, via an electronic file or access to an electronic file, a Certificate Booklet provided by HCSC to the Policyholder for delivery to each Insured. The Policyholder further agrees that it is solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to the Policyholder and, upon the Insured's request, a paper copy of the Certificate Booklet.

(h) Massachusetts Health Care Reform Act: Notwithstanding anything to the contrary in this BPA, with respect to the Employer's employees who live in Massachusetts (if any) the Employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and the Employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receives an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of thirty-five (35) hours per week.

ADDITIONAL PROVISIONS: The Village of Orland Park renewed their contract October 1, 2008 for a 15 month renewal period 10/01/2008 - 12/31/2009. Effective 1/1/2009, the account will add a $2500 Embedded Deductible HSA plan. Special open enrollment period is the month of December for a January 1 effective date.

☐ Additional Provisions are specified in the Exhibit attached hereto and made a part of this BPA.

Nancy Robertson

Sales Representative

Downers Grove 630-824-5178

District

Mike Wojcik

Producer Representative

The Horton Group

Producer Firm

10320 Orland Parkway, Orland Park, IL. 60467

Producer Address

36-3672171

Producer Tax I.D. No.

Signature of Authorized Purchaser

VILLAGE MANAGER

Title

11/25/08

Date

Witness

$_____ Amount Submitted

UNDERWRITING USE ONLY
Date BPA approved:
Signature of Underwriter

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group No.: P06652
P06870
H06652

By: PAUL G. GRIMES
Print Signer's Name Here

Signature and Title

Group Name: Village of Orland Park

Address: 14700 Ravinia Avenue

City: Orland Park State: IL Zip Code: 60462

Dated this 25th day of Nov., 2008
Month Year

BlueCross BlueShield of Illinois

APPLICATION FOR EXCESS LOSS COVERAGE
(Cost-Plus Accounts Only)

Employer Group Name: Village of Orland Park
Employer Group Address: 14700 Ravinia Avenue
Orland Park, Illinois 60462
Account Number: 206338
Employer Group Number(s): P07366
Effective Date of Policy: 01/01/2009

Is this a Unified group (Indemnity Excess Loss Coverage and HMO Excess Loss Coverage)? ☒ Yes ☐ No
If yes, please complete separate Indemnity and HMO Excess Loss Coverage Applications.

Aggregate Excess Loss Coverage: ☒ Yes ☐ No
If yes, complete items 1 through 9 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:
   - ☐ New Coverage (Select one from below):
     - ☐ Standard: Claims incurred and paid from: _____ to _____
     - ☐ "Run-in" included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____
   - ☒ Renewal of Existing Coverage:

     Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010
3. Aggregate Excess Loss Coverage shall apply to:
   - ☒ Medical Claims ☐ Vision Claims
   - ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)
   - ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims
   - ☐ Other (please specify): _____
4. Average Claim Value: $11,058.60 (per employee).
   - ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Attachment Point: 125% of the Average Claim Value.
6. Aggregate Excess Loss Limit Claim Value: $13,823.25

(equals the Average Claim Value multiplied by the Attachment Point)

7. Aggregate Excess Loss Coverage Limit:

   The Aggregate Excess Loss Coverage Limit shall equal the average number of employees during the Excess Loss Coverage Period multiplied by the Aggregate Excess Loss Limit Claim Value. In no event shall the Aggregate Excess Loss Coverage Limit be less than $124,409 as specified in Section III of the Policy.

8. Annual Premium

   (Due on the Effective Date of Policy): $0

9. The annual premium is based upon a current membership of 10 Individual Coverage Units and 0 Family Coverage Units.

Individual Excess Loss Coverage: ☒ Yes ☐ No

If yes, complete items 1 through 6 below.

1. ☐ New Coverage ☒ Renewal of Existing Coverage
2. Excess Loss Coverage Period:
   - ☐ New Coverage (Select one from below):
     - ☐ Standard: Claims incurred and paid from: _____ to: _____
     - ☐ "Run-in"included: Claims incurred from: _____ and paid on or after the Effective Date of Policy to: _____
   - ☒ Renewal of Existing Coverage:
     - Claims incurred on or after the effective date of the administration of the Group Policy by the Plan (Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) and paid on or after the Effective Date of Policy to: 01/01/2010.
3. Individual Excess Loss Coverage shall apply to:
   - ☒ Medical Claims ☐ Vision Claims
   - ☒ Outpatient Prescription Drug Claims ☐ Dental Claims (Pre-Dent)
   - ☐ For Hospital Employer Groups only: *Excludes* _____% of Home Hospital Medical claims
   - ☐ Other (please specify): _____
4. Individual Excess Loss Coverage Limit: $100,000
   - ☒ Includes Plan's Provider Access Fee ☐ Excludes Plan's Provider Access Fee
5. Premium (select one):
   - ☒ Monthly: $_____ each month **or** $65.17 per employee each month.
   - ☐ Annual: $_____
6. The premium is based upon a current membership of 10 Individual Coverage Units and 0 Family Coverage Units.

Additional Provisions:

12 month renewal period

The undersigned person represents that he/she is authorized and responsible for purchasing excess loss coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Excess Loss Coverage Policy into which this Application for Excess Loss Coverage shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). Upon acceptance, HCSC shall issue a Excess Loss Coverage

Policy to the Employer Group. Upon acceptance of this Application and issuance of the Excess Loss Coverage Policy, the Employer Group shall be referred to as the "The Policyholder."

Nancy Robertson

Sales Representative

Carl Charvat

Name of Underwriter

Signature of Authorized Purchaser

VILLAGE MANAGER

Title of Authorized Purchaser

11/25/08

Date

	UNDERWRITING AUTHORIZATION
INTERNAL USE ONLY	Date Application approved by Underwriting: _____ Signature of Underwriter: _____