FIDELITY SECURITY LIFE INSURANCE COMPANY
3130 Broadway
Kansas City, Missouri 64111

APPLICATION FOR EXCESS LOSS REIMBURSEMENT CONTRACT

GENERAL INFORMATION

1. Full Legal Name of Applicant: Williamson County
   Address of Applicant: 301 SE Inner Loop
   City: Georgetown State: TX Zip Code: 78626
2. Type of Entity: [ ] Corporation [ ] Partnership [ ] Limited Liability Co. [ ] Proprietorship [ ] Labor Union [ ] Association [ ] Trusteeship [X] Other: ______
3. Requested Effective Date: ______
4. Other Locations: ______
5. Primary Contact at Applicant: ______
6. Full Legal Name of Subsidiary or Affiliated Companies to be included: ______
   Address: ______
   City: ______ State: ______ Zip Code: ______
7. Nature of Applicant's Business: General Government, NEC SIC Code: 9199
8. Full Name of Applicant's Plan: ______
   (A signed copy of such Plan must be attached and form a part of this Application.)
9. Name and Address of Third Party Administrator: Allegiance Benefit Plan Management, Inc.
   Address: PO Box 3018
   City: Missoula State: MT Zip Code: 59806
   Social Security No. or Tax ID: ______ Phone Number: (406)721 - 2222
10. Name and Address of Writing Agent: Eric D. Smith/Smith & Associates Consulting
    (Attach a current copy of license(s) if not on file.)
    Address: 906 Shady Lane
    City: Southlake State: TX Zip Code: 76092
    Social Security No. or Tax ID: ______ Phone Number: (817)310 - 3422

11. Estimated initial enrollment: 1,385 Single: ______ Family: ______
    Spouse Only: ______ Spouse & Children ______ Children only: ______

12. Deposit Premium: $59,669

13. Covered Persons Included in your Plan:

	Yes	No
Retired Employees	X	
COBRA Beneficiaries	X	
Disabled Persons	X	

SPECIFIC EXCESS LOSS INSURANCE [X] Yes [ ] No

1. Plan Benefit Payments included in Your Plan to be covered by Specific Excess Loss Insurance:
   [X] Medical [X] Prescription Drug Expenses [ ] Other(s) ______
   [ ] Dental [ ] Vision
2. Contract Basis: Expenses Incurred from 08/01/2012 through 10/31/2013
   Paid from 11/01/2012 through 10/31/2013
3. Run-in claims Incurred prior to the Effective Date will be limited to $ N/A
4. Specific Deductible (per Covered Person) $ 225,000
5. Specific Reimbursement Maximum: $ Unlimited
   (per Covered Person excess of Specific Deductible)
6. Specific Percentage Reimbursable (excess of Specific Deductible) 100%
7. Aggregating Specific [ ] Yes [X] No
   If yes, the Aggregating Specific amount is $ N/A

8. SPECIFIC MONTHLY PREMIUM RATES:

Single	Family	Spouse only	Spouse & Child(ren)	Child(ren) only
$37.94	$37.94			

AGGREGATE EXCESS LOSS INSURANCE [X] Yes [ ] No

1. Plan Benefit Payments included in Your Plan to be covered by Aggregate Excess Loss Insurance:
   [X] Medical [X] Prescription Drug Expenses [ ] Other(s) ______
   [ ] Dental [ ] Vision
2. Contract Basis: Expenses Incurred from 08/01/2012 through 10/31/2013
   Paid from 11/01/2012 through 10/31/013
3. Run-in claims Incurred prior to the Effective Date will be limited to $ N/A
4. Aggregate Reimbursement Maximum (excess of Aggregate Annual Deductible): $ 1,000,000
5. Aggregate Percentage Reimbursable (excess of Aggregate Annual Deductible): 100%

6. AGGREGATE MONTHLY FACTOR(S)

Plan Benefits	Single	Family	Spouse only	Spouse & Child(ren)	Child(ren) only
Medical	$1,085.30	$1,085.30			
Dental					
Vision					
Prescription Drug Expenses	Included	Included			
Composite					

7. Minimum Aggregate Annual Deductible $ 18,037,686
8. Loss Limit (per Covered Person) $ 225,000
9. Monthly Aggregate Premium Rate (per Covered Person) $ 5.14
10. **Monthly Aggregate Accommodation** Option: [X] Yes [ ] No
    If Yes, Monthly Aggregate Accommodation Premium (per Covered Person) $ N/A
11. **Terminal Aggregate Liability** Option: [X] Yes [ ] No
    If Yes, Monthly Terminal Aggregate Liability Premium (per Covered Person) $ N/A

MEDICAL DATA

The Company will rely on the data below to assist in approving the Employer for Reimbursement. Note that without the Company's review and approval of each risk, the Participating Employer's Losses will not be reimbursable under the Excess Loss Reimbursement Contract; therefore, please answer the following questions.

1. Has an eligible employee or dependent received or expected to receive more than 50% of the Specific Deductible in expenses in the last 12 months? [ ] Yes [ ] No
2. Will any former employee or dependent be continuing coverage under the Plan in accordance with Federal, State, or Local law on the Effective Date of this Contract, if issued? [ ] Yes [ ] No

If yes to questions 1 or 2, list name, status, prognosis, and amount of claim (attach, sign and date a separate sheet if needed):
See Attached Large Claim Review

Name ______ DOB ______ Sex: [ ] Male [ ] Female Status ______ (Ee, Dep, COBRA, Retiree)

Diagnosis ______

Prognosis ______

Amount of Claim ______

3. Are expected benefits available from the prior insurer for presently disabled eligible employees and/or dependents? [ ] Yes [ ] No
4. Are any eligible employees or dependents presently disabled or confined in a hospital or similar facility? [ ] Yes [ ] No

Please explain any "Yes" answers to questions 3 or 4 (Please attach, sign and date a separate sheet if needed):
See Attached Large Claim Review

SPECIAL LIMITATIONS: This proposal assumes that the employer will use the current plan design through the CIGNA National PPO network(s).

DISCLOSURE

The Excess Loss Reimbursement Contract Employer Disclosure Statement must be received no earlier than 15 days prior to the effective date and no later than 15 days after the effective date. The Company reserves the right to adjust the rates, factors, deductibles and/or Special Limitations based upon information contained therein.

SIGNATURE

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

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;
2. the Plan Administrator or Third Party Administrator retained by the Applicant will be considered the Applicant's Agent, and not the Company's Agent;
3. 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 Effective Date;
4. the Company will evaluate the Applicant's risk, and may require adjustments of rates, factors, deductibles and/or Special Limitations to accommodate for abnormal risks;
5. premiums are not considered paid until the premium check or transfer is received by the Company and at the rates set forth in the Schedule;
6. this Application will be attached to and made a part of any Excess Loss Reimbursement Policy issued by the Company in connection with this Application;
7. the Applicant's Plan Document shall be the basis of any Excess Loss Insurance provided by the Company and such Plan Document conforms with applicable State and Federal laws;
8. any reimbursement under the Excess Loss Reimbursement Policy provided by the Company shall be based on eligible Plan Benefits Paid in accordance with the Plan Document;
9. claims under the Plan Document for any employee who is not at his or her customary place of employment (or scheduled vacation) on the Effective Date of the Excess Loss Reimbursement Policy will not be eligible for reimbursement under the Policy until such employee returns to active, full-time employment for at least one (1) full working day;
10. unless otherwise indicated above, claims under the Plan Document for any Covered Person who is confined in a medical facility on the Effective Date of the Excess Loss Reimbursement Policy will not be eligible for reimbursement under the Policy until such person is discharged from the hospital or similar facility; and
11. if there is any material change in the answers to the questions in this Application or the Excess Loss Reimbursement Contract Employer Disclosure Statement before the Policy effective date, the Applicant must immediately notify the Company in writing, and any outstanding quotation may be modified or withdrawn.

I represent that as of the date I signed this Application, all statements and answers recorded on this Application are true and complete and are made to obtain the insurance applied for and that the undersigned has the authority to bind the Applicant to the proposed contract. These statements are to be considered representations and not warranties. Accordingly, this Application will be part of the Contract if accepted by the Company or its authorized representative.

Dated at Williamson County this 24th day of September, 20 12

Witness [signature]
Signature of Licensed Agent

Eric Smith
(Print Name)

Applicant Williamson County
(Type or Print)

Applicant's Tax ID # 74-6000978

By ______________________
(Officer/Partner Signature)

____
(Print Name)

Title: ______________________