**Claim Exception Acknowledgement Form**

**Date:**

**Employer:**

**Plan:**

**Employee:**

**Patient:**

**Employee SSN:**

**Extra-Contractual Claim Payment:**

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I acknowledge and represent I am authorized to sign on behalf of Employer/Plan, and my signature below authorizes Luminare Health Benefits to abide by the Extra-Contractual Claim Payment described above. Employer accepts full responsibility for notifying Employee of any potential tax consequences of the Extra-Contractual Claim Payment. Additionally, I understand and acknowledge the following:

1. A payment which is made as an exception to the provisions of the Plan may not be eligible for reimbursement under the terms of the stop-loss agreement between the stop-loss carrier and Employer;

2. A payment made as an exception to the Plan may be considered taxable income to Employee;

3. If payment of the Extra-Contractual Claim Payment is made from Plan assets of the Plan, and such payment is deemed discriminatory by any regulatory body, agency, or court, there may be ramifications to the tax status of benefits paid under the Plan to the participants of the Plan; and

4. Employer and Plan will indemnify and hold Luminare Health Benefits harmless, as well as its parent, subsidiaries, affiliates, officers and employees from any and all liabilities (including, but not limited to attorney’s fees) incurred as a result of complying with the Extra-Contractual Claim Payment.

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Signature Date

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Title

cc: Location President