SilverSummit Health Plan

CONFLICT OF INTEREST DISCLOSURE STATEMENT

Preliminary note: In order to be more comprehensive, this statement of disclosure/questionnaire also requires you to provide information with respect to certain parties that are related to you. These persons are termed “affiliated persons” and include the following:

a. Your spouse, domestic partner, children) and/or their spouses, mother, father, mother-in-law, father-in-law, brother or sister and/or their spouses
b. Any corporation or organization of which you are a board member, an officer, a partner, participate in management or are employed by, or are, directly or indirectly, a debt holder, the beneficial owner of any class of equity securities or in which you have an ownership or financial interest; and
c. Any trust or other estate in which you have a substantial beneficial interest or as to which you serve as a trustee or in a similar capacity.

1. NAME OF EMPLOYEE OR BOARD MEMBER: (please print) Haran Ravindran, MD

2. CAPACITY:
   ____ Board of directors
   ____ Executive committee
   ____ Officer
   __X__ Committee member
   ____ Staff (position):_____

3. Have you or any of your affiliated persons provided services or property to SilverSummit in the past two years and / or do you expect to in the future?

   Yes_____ NO_____

   If yes, please describe the nature of the services or property and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

   _____

   _____

4. Have you or any of your affiliated persons purchased services or property from SilverSummit Health Plan in the past two years and/or do you expect to in the future?

   Yes_____ NO_____

5. If yes, please describe the purchased services or property and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

   Please indicate whether you or any of your affiliated persons had any direct or indirect interest in any business transaction(s) in the past two years to which SilverSummit Health Plan was or is a party and / or do you expect to in the future?

   Yes_____ NO_____

   If yes, describe the transaction(s) and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

   _____

   _____

6. Were you or any of your affiliated persons indebted to pay money to SilverSummit Health Plan at any time in the past two years (other than travel advances or the like) and / or do you expect to in the future?

   If yes, please describe the indebtedness and if an affiliated person is in involved, the identity of the affiliated person and your relationship with that person:

   Yes_____ NO_____

7. In the past two years, did you or any of your affiliated persons receive, or become entitled to receive, directly or indirectly, any personal benefits from SilverSummit Health Plan or as in a result of your relationship with SilverSummit Health Plan that in the aggregate could be valued in excess of $1,000 that were not or will not be compensation directly related to your duties to SilverSummit Health Plan and/or do you expect to in the future?

   Yes_____ NO_____

If yes, please describe the benefit(s) and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

8. Are you or any of your affiliated persona a party to or have an interest in any pending legal proceedings involving SilverSummit Health Plan

   Yes_____ NO_____

   If yes, please describe the proceeding(s) and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

9. Are you aware of any other events, transactions, arrangements or other situations that have occurred or may occur in the future that you believe should be examined by SilverSummit Health Plan [board or a duly constituted committee thereof] in accordance with the terms and intent of SilverSummit Health Plan‘s conflict of interest policy?

   Yes_____ NO_____

   If yes, please describe the situation(s) and if an affiliated person is involved, the identity of the affiliated person and your relationship with that person:

   _____
   _____

10. Are any immediate family members, as defined above, a current or former employee of, consultant with, or lobbyist for the Nevada Medicaid Agency?

    Yes_____ NO_____

If yes, please describe the employment, the identity of the affiliated person and your relationship with that person.

I HEREBY CONFIRM that I have read and understand SilverSummit Health Plan‘s conflict of interest policy and that is my responses to the above questions are complete and correct to the best of my information and belief. I agree that if I become aware of any information that might indicate that this disclosure is inaccurate or that I have not compiled with this policy. I will notify [designated officer or director] immediately.

_____ _____

Signature Date: