

Employer Medical Risk Evaluation Questionnaire

To be completed by the employer and submitted with Application for Group Health Insurance. (For 51+ Employees)

Employer Tax ID Number: 38-_____ Requested Effective Date of Insurance: _____

Employer Name: _____

Current Carrier: _____ Plan Design: _____

Current Rates: EE _____ ES _____ EC _____ F _____

Renewal Rates (attach most recent renewal notice from current carrier): EE _____ ES _____ EC _____ F _____

Employer Contribution Percentage of Premium: EE _____ ES _____ EC _____ F _____

Does your current Health Plan provide you with claims experience? If yes, please include. Yes No

Please answer the following questions:

1. Has any employee or dependent had claims of \$10,000 or more in the last 12 months? Yes No

2. Has any employee or dependent been hospitalized or had surgery within the last 24 months? Yes No

3. Are there any covered employees or dependents who have any existing conditions which may require advice, diagnosis or treatment, surgery or hospitalization? Yes No

4. Is any employee or dependent currently pregnant or have any preterm infants been delivered in the last 12 months? Yes No

5. Check below if any employees or dependents received treatment during the last 5 years for any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Brain Disorders (e.g. Multiple Sclerosis or Epilepsy) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease (e.g. Cirrhosis or Hepatitis) |
| <input type="checkbox"/> Heart or Blood Disease | <input type="checkbox"/> Auto-immune Disease (e.g. Rheumatoid Arthritis or AIDS) |
| <input type="checkbox"/> Diabetes | |

6. Has any employee requested an FMLA leave or been on short-term disability or long-term disability or been absent from work due to an illness or injury for more than five (5) consecutive working days within the last 12 months? Yes No

If yes, please list (attach additional list, if needed)

List E for Employee D for Dependent	Year Illness, FLMA Leave or Disability Began Began Returned or Ongoing	Type of Illness, Injury or Disability
_____	_____	_____
_____	_____	_____

7. Are any former employees or dependents currently on, or eligible for, continuation under COBRA*? Yes No

If yes, please list employees and dependents (attach additional list, if needed)

List E for Employee D for Dependent	Year Illness, FLMA Leave or Disability Began	Type of Illness, Injury or Disability

* Individual health questionnaires may be requested on COBRA participants, disabled individuals or serious medical conditions. Please provide details for "yes" answers to the questions 1 through 5. (If more space is needed, attach additional list.)

Question #	List E for Employee S for Spouse C for Child	Condition/Medication	Years of Treatment	Estimated Dollar Amount of Claims	Prognosis/ Current Treatment

We declare that the information on this form is true and accurate to the best of our knowledge. We understand that it will be used as a basis for underwriting our Group Health Plan.

We also understand that the submission of false or misleading information may result in the adjustment of rates back to the original effective date or the immediate termination of the group and/or employee.

Employer's Signature	Title	Years with Company
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Agent	Insurance Agency	Date
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Gatekeeper (If different from Employer or Agent)	Title
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