Group Health Questionnaire

COMPANY INFORMATION

Please list all companies that are considered to be related (part of the same control group) as defined in IRS Sec. 404 (b), IRS Sec. 404(c) and IRS Sec. 1563 (a). For more information you can reference IRS Publication 704 and/or consult your accountant or attorney for clarification.

Company Name	Address	City, State, Zip	SIC Code	Included in this proposal	Number of employees

BENEFITS INFORMATION – PLEASE COMPLETE IN TOTAL FOR ALL COMPANIES BEING INCLUDED IN RFP.

Current Health Carrier:				Renewal Date:	
Waiting Period for Benefits:		Number of full-time employees?		# of employees enrolled:	
Is your health insurance currently through a PEO?	☐ Yes ☐ No	If yes, name of PEO:			
Any ineligible class of employees?	☐ Yes ☐ No	If yes, which class:			
Current Contribution Class Definitions:	Class 1:		Class 2:		Class 3:	
Current Employer Contribution:	Class 1*:		Class 2:		Class 3:	

MEDICAL PROFILE

Plan Sponsor: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents.

Has anyone been treated for a serious illness, been hospitalized and/or had surgery in the past 5 years? Or is anyone currently hospitalized, confined at home or in a treatment facility, incapable of self support because of a disability? Or been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	**To the best of my knowledge:** Yes ☐ No ☐

(If "yes") Check the appropriate box below:

☐ AIDS or testing HIV positive	☐ Urinary System Disease	☐ Stroke/Paralysis
☐ Transplants	☐ Liver Disease	☐ Digestive System Disease
☐ Arthritis	☐ Back Disorder	☐ Cardiovascular System Disease
☐ Blood Disorder	☐ Emphysema/Pulmonary	☐ Other:_____
☐ Musular/Skeletal System Disorder	☐ Heart/Circulatory Disease	
☐ Diabetes	☐ Nervous System Disorder	
☐ Neurological Disorder	☐ Cancer/Tumor	

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ADDITIONAL INFORMATION

If you answered "yes" to any of the previous medical questions, please provide the following information with a likely serious continuing condition (use additional sheet if necessary).

EE Or Dep	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	$ Amount of Prior Claims	Prognosis/ Current Treatment

Are there any employees or dependents pregnant? If yes, please provide due date and note below if normal, high risk, multiple birth or preterm labor with this pregnancy.	To the best of my knowledge: Yes ☐ No ☐

Name of employee or dependent	Due Date	Type of pregnancy (normal, high risk, preterm, multiple)

COBRA CONTINUANCE

List any current COBRA/state continuation participants or employee or dependent eligible for coverage that has not yet enrolled.

Name of Individual	Employee or Dependent?	Qualifying Event	COBRA/Continuation Effective Date	Eligible but not yet elected?
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

DISABLED ENROLLEES

List any employees or dependents who are on the health plan that are disabled.

Name of Individual	Disability	Qualifying Event

Group Health Questionnaire
Premium Rates History & Plan Design Details

Plan 1 Name: / Carrier:	Total # Enrolled	Renewal Rates — Date Effective	Most Recent 12 Months	13 - 24 Months Prior	Plan Type (if other, list below)
Employee Only					
Employee + Spouse					
Employee + Child(ren)					
Employee + Family					

Annual Deductible (Individual)		Out-of-pocket Maximum (*excluding* deductible)		Office Visit Copay		Rx 1	Rx 2	Rx 3
Co-Insurance (%)								

Plan 2 Name: / Carrier:	Total # Enrolled	Renewal Rates — Date Effective	Most Recent 12 Months	13 - 24 Months Prior	Plan Type (if other, list below)
Employee Only					
Employee + Spouse					
Employee + Child(ren)					
Employee + Family					

Annual Deductible (Individual)		Out-of-pocket Maximum (*excluding* deductible)		Office Visit Copay		Rx 1	Rx 2	Rx 3
Co-Insurance (%)								

Plan 3 Name: / Carrier:	Total # Enrolled	Renewal Rates — Date Effective	Most Recent 12 Months	13 - 24 Months Prior	Plan Type (if other, list below)
Employee Only					
Employee + Spouse					
Employee + Child(ren)					
Employee + Family					

Annual Deductible (Individual)		Out-of-pocket Maximum (*excluding* deductible)		Office Visit Copay		Rx 1	Rx 2	Rx 3
Co-Insurance (%)								

Plan 4 Name: / Carrier:	Total # Enrolled	Renewal Rates — Date Effective	Most Recent 12 Months	13 - 24 Months Prior	Plan Type (if other, list below)
Employee Only					
Employee + Spouse					
Employee + Child(ren)					
Employee + Family					

Annual Deductible (Individual)		Out-of-pocket Maximum (*excluding* deductible)		Office Visit Copay		Rx 1	Rx 2	Rx 3
Co-Insurance (%)								

- ***Attach a copy of your benefit & billing summary for each plan and year listed above.***
- ***Include carrier claims report if available.***

Group Health Questionnaire

I understand that PEO uses information provided by us to determine the availability of benefits as well as to establish rates for such products and services. I understand that failing to provide accurate and complete information and/or making material misrepresentations to PEO, Blue Cross Blue Shield or any other carrier being provided this documentation may result in rates for certain products and services being adjusted or the products and services being withdrawn.

Information on this form is considered valid for effective dates within 90 days of date signed. I will notify the PEO and any prospective carrier with any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage with said group. It is understood that it is my responsibility to make any proposed carrier aware of a change and to not just rely on PEO. I understand that Blue Cross Blue Shield or any other carriers reserve the right to re-underwrite if more than 90 days has elapsed or based on a change in underwriting information submitted.

_____

Prospective Client Signature (required)

_____

Broker Signature (if applicable)

_____

Date