CIGNA Group Risk Appraisal

Company Name		Industry		SIC Code
Address		City/State		Zip
Producer Name	Producer Firm			Phone
Renewal Date	ER Contribution % EE_____ Dep_____		Eligibility Period ______ Days	
# Eligible Employees	# Covered Employees		# COBRA/State Continuees	

5 Year Carrier History	Current Rates:	Renewal Rates:
Carrier: ______________________ Eff. Date_________	EE Only ______________	EE Only ________________
Carrier: ______________________ Eff. Date_________	EE/Spouse ______________	EE/Spouse ________________
Carrier: ______________________ Eff. Date_________	EE/Child ______________	EE/Child ________________
	EE/Fam ______________	EE/Fam ________________

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents.
IMPORTANT: Your answers must include all COBRA and State Continued Individuals covered by your current plan.

Yes	No	A.	Are any employees, dependents or COBRA continues considered disabled?
Yes	No	B.	Are any covered persons contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery?
Yes	No	C.	Are any covered persons pregnant? If Yes, how many? ______
Yes	No	D.	Has any employee missed 10 or more consecutive days of work in the last 12 months due to injury or illness?
Yes	No	E.	Has the Group or Producer/Agent requested and/or received paid claim information within the past 6 months from the current carrier? If yes, please provide all claim information received.
Yes	No	F.	Within the past 12 months, has any covered person had a serious continuing claim (i.e., chronic or ongoing condition likely to cost $25,000 or more per year for treatment) due to a mental or physical disorder? If yes, check the appropriate box(es) below.

	Aids/ Immune disorders		Cardiovascular		Infertility		Neurological
	Alcohol Abuse		Diabetes		Intestines		Pancreas
	Arthritis		Drug/ Substance Abuse		Kidney		Skin
	Back, Neck		Epilepsy		Liver		Stomach
	Blood		Ears/ Eyes		Lungs		Stroke/ Paralysis
	Bone/ Joint		Emphysema/ Pulmonary		Lupus		Venereal
	Brain		Heart Disease		Mental/ Nervous		Other (detail below)
	Cancer/ Tumor		High Risk Pregnancy		Migraines		

If you answered "yes" to questions A, B, C, D or F, please provide the following information for each individual with a likely serious continuing condition. Use an additional sheet if necessary.

EE, Dep or Continuee	Age	Nature of Condition	Dates of Treatment	Names of Medication	$ Amount of Prior Claims	Current Status

I represent to the best of my knowledge the information I have provided is accurate. I understand that CIGNA will rely on this information to determine whether a proposal will be issued. If errors or omissions are subsequently found, CIGNA reserves the right to revise rates or rescind the quote.

Employer Contact Name/Title	Signature	Date