Required for all Groups

# Group and Plan Information

| Group Information | |
|---|---|
| **Group Name:** | **Desired Effective Date:** |
| **Address:** | **City / ZIP/ County:** |
| **Phone:** | **Nature of Business:** |
| **Years in Business:** | **Fed Tax ID:** |
| **Total # of Full - time Employees:** | **% Participation:** |
| **Number of EE's residing Out of Area:** | **% Turn Over:** |
| **Location(s) with zip-code:** | **Number of COBRA Enrollees:** |
| **Current Health Carrier:** | **How long?** |
| **Employer Contribution (Medical): Employee** | **Dependent** |
| **Employer Contribution(Dental): Employee** | **Dependent** |
| **Waiting Period:** | **Previous Carriers (5 years):** |

**Medical Rates and Plan Information**

| Plan 1 | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.) |
|---|---|---|---|---|---|
| Renewal | | | | | |
| Current | | | | | |
| Prior | | | | | |

| Plan 2 | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.) |
|---|---|---|---|---|---|
| Renewal | | | | | |
| Current | | | | | |
| Prior | | | | | |

| Plan 3 | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.) |
|---|---|---|---|---|---|
| Renewal | | | | | |
| Current | | | | | |
| Prior | | | | | |

| Health & Wellness Initiatives | Date of Last Health Fair: | | Years In Place: | |
|---|---|---|---|---|
| | | | | |

**Dental Rates and Plan Information**

| Plan 1 | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Description |
|---|---|---|---|---|---|
| Renewal | | | | | |
| Current | | | | | |
| Prior | | | | | |

| Plan 2 | Employee Only | Employee + Spouse | Employee + Child(ren) | Family | Description |
|---|---|---|---|---|---|
| Renewal | | | | | |
| Current | | | | | |
| Prior | | | | | |

**Additional Information**

Client Notes: (Please share any additional information that you would like the underwriter to know:

Required for all Groups

# Group Risk Evaluation

Group Name

## Questionnaire

1. Have covered employees or dependents ever had, consulted a health care professional, or received counseling or treatment for:(Circle all that apply and explain below)?

| | | |
|---|---|---|
| AIDS / HIV | Heart Disease | Multiple Sclerosis |
| Alcohol/Substance abuse | Hodgkin's Disease / Lymphoma | Muscular Dystrophy |
| Blood Disorders | Hypertension | Nervous System / Muscular |
| Cancer | Infertility | Organ Disorder |
| Cerebral Palsy | Kidney / Urinary | Rheumatoid Arthritis |
| Colitis | Leukemia | Sarcoidosis |
| Crohn's Disease | Liver | Sexually Transmitted Diseases |
| Diabetes | Lung | Strokes |
| Digestive System | Lupus | Transplants |
| Emphysema | Mental / Emotional | Tumors |

2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section? Yes ☐ No ☐

3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years? Yes ☐ No ☐

4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years? Yes ☐ No ☐

5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months? Yes ☐ No ☐

6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare? Yes ☐ No ☐

## Additional Details

For any question above answered "Yes", please complete the following:

| Question # | Employee or dependent Age & Gender | List condition, disorder, disease, problem and treatment | Dates of care: first / last due date if pregnant | Cost of care: actual or expected | Health status |
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## Signature

I certify to the best of my knowledge that the above information is true, complete and accurate and acknowledge that any coverage issued by the Plan will be issued in reliance thereon.

| | | |
|---|---|---|
| Employee Signature | Title | Date |
| Agent Signature | Agency | Date |

For Groups with less than 50 Employees

# Individual Health Questionnaire

## Employee Information

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Group Name: | | | | YES | NO | | YES NO |
| Employee's Name: | Age: | | Enroll: | ☐ | ☐ | If no, other coverage? | ☐ ☐ |
| Spouse's Name: | Age: | | Enroll: | ☐ | ☐ | If no, other coverage? | ☐ ☐ |
| Number of Dependent Children: | Age(s): | | Enroll: | ☐ | ☐ | If no, other coverage? | ☐ ☐ |
| Employee's Height: _____ ft. _____in. | | | Spouse's Height: _____ ft. _____in. | | | | |
| Employee's Weight: _____now; _____ one year ago | | | Spouse's Weight: _____now; _____ one year ago | | | | |

## Health Information

Are you or your dependents afflicted or diagnosed with a major disease or illness? (If yes, explain below) YES ☐ NO ☐

Are you or your dependents anticipating any medical or surgical treatment in the next year? (If yes, explain below) YES ☐ NO ☐

Do you or your dependents currently take any prescription medication? (If yes, explain below) YES ☐ NO ☐

Have you or your dependents used any type of tobacco product within the past 5 years? (If yes, explain below) YES ☐ NO ☐

**Health Information** (Please use the back of the form if needed)

Please include: Blood Disorders, Cancer (include type), Congenital Disorders, Cystic Fibrosis, Diabetes, Pregnancy (anticipated complications), Liver Disease, Heart Disease, Transplants (include type), Multiple Sclerosis, or other major illnesses.

| Individual Name | Date (First / Last) | | Diagnosis | Prognosis | Expense |
|---|---|---|---|---|---|
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**Prescription Medication Information** (Please use the back of the form if needed)

| Individual Name | Date (First / Last) | | Name and Dosage of Medication | Reason for Medication | Expense |
|---|---|---|---|---|---|
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## Signature

I certify that the information stated above is true and correct and acknowledge that any coverage issued by the Plan will be issued in reliance thereon.

| Employee Signature | Date |
|---|---|