GROUP RISK PROFILE

Anthem BlueCross BlueShield
And Its Affiliate HealthKeepers, Inc.

Name of Business: _____ Former Name of Business: _____

Address :_____ City_____State_____Zip_____

Number of Years in Business:_____Type of Business:_____ Group Administrator Name:_____

Current Carrier:_____ Time Period Covered:_____

Previous Carrier:_____ Time Period Covered:_____

Has group been previously insured by Anthem Blue Cross and Blue Shield and/or Anthem affiliated HMO? Yes No

If Yes, Group Number and Time Period Covered:_____

ELIGIBILITY / PARTICIPATION INFORMATION

		NOT ENROLLING BECAUSE					
	Enrolling in Group Health Plan	Not covered due to employer waiting period	Covered under another Group Health Plan, individual Coverage, or Spouse Coverage	Enrolled in Medicare, TRICARE, or FEP	Part-time employees	Elects not to have Group Coverage	TOTAL EMPLOYEES
Number of Regular, Full-time Employees: Those who work 30 or More Hours Per Week	_____	_____	_____	_____	_____	_____	_____

Is the group changing eligibility criteria and requesting a quote for a population that is different than currently covered? ___No ___Yes

Is the group headquartered in Virginia? ___No ___Yes If No, where is the group located:_____

How many employees live or work outside of Virginia? _____

Are any early Retirees currently covered on your Plan? ___No ___Yes If Yes, number of early retirees:_____

Are COBRA participants currently covered on your Plan? ___No ___Yes If Yes, number of COBRA particpants:_____

Employer Contribution: Employee_____% or $_____ Dependent_____% or $_____

Is your current health care plan either self-insured or partially self-insured? ☐ No ☐ Yes

If "yes", please describe your company's liability and provide two (2) years of claims experience._____

Rates/Benefit/Experience Profile

Please provide the following information and/or include copies of your most recent and previous renewal packages.

Current Period: From_____Through_____	Enrollment	Rates
Employee	_____	_____
Employee and Child	_____	_____
Employee/Children	_____	_____
Employee/Spouse	_____	_____
Employee/Family	_____	_____
Total:	_____	

Renewal Period: From_____ Through_____	Enrollment	Rates
Employee	_____	_____
Employee and Child	_____	_____
Employee/Children	_____	_____
Employee/Spouse	_____	_____
Employee/Family	_____	_____
Total:	_____	

Benefit Summaries: Please attach the benefit summaries for each benefit plan currently offered.
Claims Experience History: Please attach claims experience from current carrier if available.

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MEDICAL INFORMATION

1. Identify to the best of your ability any employees or dependents that have been treated or ***expect to be treated*** for any of the following conditions. If yes, **indicate *the number*** of employees/dependents in the next box provided.

	Yes	#		Yes	#		Yes	#
Acquired Immune Deficiency Syndrome (AIDS) ……..	☐	☐	Disease/Disorder of Spine or Back ……..…...	☐	☐	Muscular/Nervous System Disorder…….....	☐	☐
Alcohol or Drug Abuse …….	☐	☐	Heart Disease/Angina……..	☐	☐	Organ Transplant …….	☐	☐
Cancer ……	☐	☐	Kidney/Bladder Disease/Disorder ..	☐	☐	Respiratory Disease/Disorder…	☐	☐
Connective Tissue Disease ……	☐	☐	Liver Disease ……..	☐	☐	Stroke ……	☐	☐
Epilepsy ……	☐	☐	Mental Illness……..	☐	☐	Stomach/Intestinal Disorder….	☐	☐
Diabetes…….. ☐ Diet ☐ Oral ☐ Insulin	☐	☐						

Please give dates, prognosis, and details:_____

_____

_____

Information provided on this Group Risk Profile will be used to calculate rates for group health coverage through Anthem Blue Cross and Blue Shield and Anthem affiliate HealthKeepers, Inc. When answering questions on this document (other i.e. "health statement" etc) the information provided for each individual should include only information about that individual, and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic testing, genetic services, genetic counseling, or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

2. Has anyone been hospitalized within the past twelve months? ☐ No ☐ Yes If yes, give details: _____

_____

_____

3. Identify to the best of your ability the number of employees and dependents incurring medical costs within the past twelve months of $10,000 or more: _____. Please provide details:_____

_____

Certification

The undersigned Employer (and/or Broker) certifies that all of the information shown on this form is correct and complete to the best of his or her knowledge. It is understood that Anthem Blue Cross and Blue Shield and/or Anthem affiliate HealthKeepers, Inc. intend to rely on this information as part of the premium determination process. It is also understood that, if the information is not correct and complete to the best of the Employer's (and/or Broker's) knowledge, Anthem Blue Cross and Blue Shield and/or Anthem affiliate HealthKeepers, Inc. may revise the premiums accordingly.

_____	_____	_____
Group Administrator Name and Title	Telephone Number	Date
_____	_____	_____
Broker Name (if applicable)	Agency Name (if applicable)	Date

GROUP RISK PROFILE

Answers to Questions from Page 2

4. ADDITIONAL DETAILS

Question Number: