CareFirst BlueCross BlueShield

Group Hospitalization and Medical Services, Inc.
840 First Street, NE
Washington, DC 20065

CareFirst BlueChoice

CareFirst BlueChoice, Inc.
840 First Street, NE
Washington, DC 20065

GROUP SCREENING QUESTIONNAIRE
(For District of Columbia Groups with 51+ Employees)

Check one or both companies for which application is being sought: ☐ CareFirst BlueCross BlueShield ☐ CareFirst BlueChoice, Inc.

A. Company Identification:

Name of Company: _____ Phone: _____ Date: _____

Location: _____
Street City State Zip Code

Type of Business: _____ SIC Code: _____

B. Health Risk Assessment:

1. To the best of your information and belief, indicate beside each condition the total number of eligible persons* to be covered who have been treated, are currently being treated or are expected to be treated for a condition or serious illness, such as, but not limited to:

___AIDS; HIV+ (Positive HIV Test);
___Cancer;
___Central Nervous System Disease or Multiple Sclerosis;
___Chronic Heart, Kidney, or Liver Disease;
___Diabetes;
___Existing Pregnancy Only;
___Hemophilia or Blood Disorders;
___Lung Disorders, COPD, or Asthma;
___Psychiatric Disorders;
___Congenital (Birth) Defects or Disorders;
___Substance Abuse;
___Other (List):

Number	Condition/Illness
_____	_____
	_____

2. To the best of your information and belief, is there any eligible person who has incurred $10,000 or more in medical expenses over the past 12 calendar months, or who is expected to incur $10,000 or more in medical expenses over the next 12 calendar months? **Yes** ☐ **No** ☐

If YES, please provide a brief description of the diagnosis and treatment for each individual:

_____

_____

C. Current Coverage Information:

Current Carrier:

		Individual	Individual & Child(ren)	Individual and Adult	Family	Employer Contribution	Type of Benefit Plan	Estimated No. of Contracts
Benefit 1	**Current Rates**						☐ HMO ☐ PPO ☐ Point of Service ☐ Indemnity	
	Renewal Rates							
Benefit 2	**Current Rates**						☐ HMO ☐ PPO ☐ Point of Service ☐ Indemnity	
	Renewal Rates							
Benefit 3	**Current Rates**						☐ HMO ☐ PPO ☐ Point of Service ☐ Indemnity	
	Renewal Rates							
Benefit 4	**Current Rates**						☐ HMO ☐ PPO ☐ Point of Service ☐ Indemnity	
	Renewal Rates							

*Eligible persons include owners, partners, and full-time employees; COBRA Extendees (former employees covered by your present health care carrier pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985); and the eligible family members, if any. 1099 Recipients are not eligible. Seasonal employees are not eligible. Full-time employees are defined as those who work on average at least thirty (30) hours per week.

PLEASE COMPLETE AND SIGN THE BACK OF THIS QUESTIONNAIRE

C. Current Coverage Information (continued):

Projected Enrollment	
Number of full-time Employees actively at work:	
Number of Employees enrolling in Spousal Coverage / Parental Coverage / Military Coverage:	
Number of Employees opting out of coverage:	
Number of COBRA Extendees:	
Will Part-Time Employees (17.5 hrs/wk) be covered?	**Yes** ☐ **No** ☐
If covering, number of Part-Time Employees:	
Number of Disabled former Employees:	
Number of Retirees:	

D. Prior Coverage Information:

1. Has the Company's coverage with CareFirst and/or CareFirst BlueChoice, Inc. been cancelled within the last 18 calendar months? If so, please list the prior Group Number: _____. Any outstanding balances owed by the Company to CareFirst and/or CareFirst BlueChoice, Inc. must be reconciled before the Company will be approved for group coverage. **Yes** ☐ **No** ☐

2. What is the number of carriers that the Company has had coverage with in the past five (5) years? ☐

3. Has the Company's coverage been cancelled (or is it in the process of being cancelled) by the Company's present health care carrier? **Yes** ☐ **No** ☐

4. Has the company filed for bankruptcy (or is in the process of filing for bankruptcy) within the last three (3) years? If yes, to 3 or 4 please explain: **Yes** ☐ **No** ☐

_____

_____

E. Review and Signature:

It is hereby understood and agreed that:

The information provided herein is complete and correct to the best of my information and belief.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Please check your role for the Group:

☐ **Group Administrator/Representative**

☐ **Broker**

_____ _____

Signature Printed Name

_____ _____

Title Date