



CareFirst of Maryland, Inc.  
 A Not-for-Profit Health Service Plan  
 10455 Mill Run Circle  
 Owings Mills, MD 21117

**GROUP SCREENING QUESTIONNAIRE  
 (For Groups with 51+ Employees)**



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

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:

- |  |   |
|--|---|
| <input type="checkbox"/> AIDS; HIV+ (Positive HIV Test);                       | <input type="checkbox"/> Lung Disorders, COPD, or Asthma;                     |
| <input type="checkbox"/> Cancer;   | <input type="checkbox"/> Psychiatric Disorders;                               |
| <input type="checkbox"/> Central Nervous System Disease or Multiple Sclerosis; | <input type="checkbox"/> Congenital (Birth) Defects or Disorders;             |
| <input type="checkbox"/> Chronic Heart, Kidney, or Liver Disease;              | <input type="checkbox"/> Substance Abuse;                                     |
| <input type="checkbox"/> Diabetes;   | <input type="checkbox"/> Other (List): <u>Number</u> <u>Condition/Illness</u> |
| <input type="checkbox"/> Existing Pregnancy Only;                              | _____   |
| <input type="checkbox"/> Hemophilia or Blood Disorders;                        | _____   |

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						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
Benefit 2	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
Benefit 3	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
Benefit 4	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> 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); or former employees covered by a Maryland Continuation of Coverage provision; 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):**

<b>Projected Enrollment</b>					
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:					
Number of former employees covered by a Maryland Continuation of Coverage provision:					
Will Part-Time Employees (17.5 hrs/wk) be covered?	<table border="0"> <tr> <td><b>Yes</b></td> <td><b>No</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<b>Yes</b>	<b>No</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Yes</b>	<b>No</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
If covering, number of Part-Time Employees:					
Number of Disabled former Employees:					
Number of Retirees:					

**D. Prior Coverage Information:**

- 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.
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
  - What is the number of carriers that the Company has had coverage with in the past five (5) years?
  - Has the Company's coverage been cancelled (or is it in the process of being cancelled) by the Company's present health care carrier?
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
  - 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:
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
- 
- 

**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.

**Please check your role for the Group:**       **Group Administrator/Representative**  
 **Broker**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

CareFirst BlueCross BlueShield is the business name of CareFirst of Maryland, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.