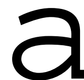

CIGNA HealthCare
Group Risk Questionnaire

In order to prepare a quote, we will need an employee census in MS Excel format that includes each eligible employee's Home Zip Code, Gender, Date of Birth, Tier Level, and Plan Name (if more than one plan is offered).

A. Company Identification:

Legal Name of Company: ______________________

Address: ______________________

SIC Code/Type of Business: ______________ Company Established In: __________

Total Number of Eligible Employees: __________ Total Number of Participating Employees: __________

Total Number of COBRA Participants: __________ Is Coverage Extended to Retirees: __________

Total Number Retired Participants: __________ Waiting Period for New Hires: __________

What is the group's Average Contract Size (ACS is the # of Members vs. Subscribers)? __________

Have there been changes (+/- 10%) in employees over the last 24 months? __________ If yes, explain. ______________________

Requested Effective Date of Coverage: __________ Requested Proposal Due Date: __________

B. Health Risk Assessment:

	Question	Answer
1)	Within the last 12 months, have any of your employees or their dependents had a large claim (chronic or ongoing medical condition) that has or is likely to cost $25,000 or more per year?	☐ Yes ☐ No ☐ Not to my knowledge
2)	Within the last 3 years, have any of your employees or their dependents been diagnosed with, received treatment for, or are currently receiving treatment for any of the below conditions?	☐ Yes ☐ No ☐ Not to my knowledge
3)	Within the last 12 months, has any employee missed more than 10 consecutive days of work due to illness or injury?	☐ Yes ☐ No ☐ Not to my knowledge
4)	Are there any employees with ongoing medical conditions or disabilities?	☐ Yes ☐ No ☐ Not to my knowledge

PLEASE NOTE: If you answered YES to any of the above questions, please check the appropriate box(es) below and provide a brief description of the diagnosis and treatment for each individual on Page 2:

- ☐ AIDS/Immune Disorders
- ☐ Alcohol Abuse
- ☐ Arthritis
- ☐ Back/Neck
- ☐ Blood
- ☐ Bone/Joint
- ☐ Brain
- ☐ Cancer/Tumor
- ☐ Cardiovascular
- ☐ Diabetes
- ☐ Drug/Substance Abuse
- ☐ Epilepsy
- ☐ Ears/Eyes
- ☐ Emphysema/Pulmonary
- ☐ Heart Disease
- ☐ High Risk Pregnancies
- ☐ Infertility
- ☐ Intestines
- ☐ Kidney
- ☐ Liver
- ☐ Lungs
- ☐ Lupus
- ☐ Mental/Nervous
- ☐ Migraines
- ☐ Neurological
- ☐ Obesity
- ☐ Organ Transplants
- ☐ Pancreas
- ☐ Stomach
- ☐ Stroke/Paralysis
- ☐ Other, Detail Below:

____

____

Nature of Condition	Age	Diagnosis (Month/Year)	Prognosis/Current Treatment	$ Amount of Claim(s)

C. Carrier Information:

Current Carrier: ______________________ Date coverage began w/Current Carrier: ______________

Please provide the Prior Carrier History for the past 5 years:

Carrier Name	From	To

If rates are not provided below, are they provided in the RFP? ______________________

Please indicate (by Plan #) which of the below plans is Open Access, if any: ______________________

Plan #1		Employee	Spouse	Child	Children	Family
☐ HMO ☐ POS ☐ PPO ☐ HRA ☐ HSA	Current Rates:	$_____	$_____	$_____	$_____	$_____
	Renewal Rates:	$_____	$_____	$_____	$_____	$_____
Plan #2		**Employee**	**Spouse**	**Child**	**Children**	**Family**
☐ HMO ☐ POS ☐ PPO ☐ HRA ☐ HSA	Current Rates:	$_____	$_____	$_____	$_____	$_____
	Renewal Rates:	$_____	$_____	$_____	$_____	$_____
Plan #3		**Employee**	**Spouse**	**Child**	**Children**	**Family**
☐ HMO ☐ POS ☐ PPO ☐ HRA ☐ HSA	Current Rates:	$_____	$_____	$_____	$_____	$_____
	Renewal Rates:	$_____	$_____	$_____	$_____	$_____

D. Employer Contribution Information:

☐ Fixed Dollar Amount: Employee: ________ Dependent: ________

☐ Uniform Percentage: Employee: ________ Dependent: ________

☐ Other (Please Explain): ________________________

E. Claims Experience:

If claims experience is available, is at least 12 months of experience being provided? ________

Are the claims paid or incurred in the experience provided? ________

Is large claims data (including diagnosis, prognosis & amount paid) being provided? ________

Is the claims experience net or gross of large claims? ________

Is at least 12 months of monthly enrollment being provided? ________

What is the current pooling level? ________ What is the requested pooling level? ________

F. Disease Management/Wellness:

Does the group currently have a Disease Management Program? ________

Is Disease Management or Wellness being requested? If YES, please include details in RFP. ________

G. Broker Information:

Who is the Broker of Record: ________________

What % of Commissions are to be included with this quote? ________________

H. Miscellaneous Information:

Reason for soliciting proposals: ☐ Cost ☐ Dissatisfied with Carrier ☐ Dissatisfied with Plan(s) ☐ Market Check ☐ Other: _____

I. Company Certification:

This questionnaire is intended to help accurately underwrite your company's request for group insurance. The undersigned Employer (and/or agent) certifies that all of the information shown on this form is correct and completed to the best of his or her knowledge. It is understood that the carriers intend to rely on this information as part of the premium determination process. It is also understood that the carrier, if the information is not correct and complete to the best of the Employer's (and/or agent's) knowledge, the carrier may revise the premiums accordingly.

Completed By: ________________ Signature: ________________

Title: ________________

Date: ________________

Agent's Name: ________________ Signature: ________________