

Group Risk Questionnaire

This is a required form and must be completed by all midsize to large groups. (51 or more eligibles)

A. Company Information

Group Name: _____ Effective Date: _____
 Group Address: _____ City, State, Zip: _____
 Broker: _____ Incumbent Broker: Yes / No _____
 Current Carrier: _____ How many Years? _____ Number of Carriers in the Past 3 Years?: _____
 Current Plan Design: _____ (Please attach Plan Summary Description and Census)
 Nature of Business / SIC Code: _____

B. General Information – Claims, Rate History, and Eligibility Criteria

Rates	Current HMO	Current POS/PPO	Renewal HMO	Renewal POS/PPO	ER Contribution %	Number of Active: _____
Subscriber	\$	\$	\$	\$		Number of Cobra: _____
Subscriber/Spouse	\$	\$	\$	\$		Number Early Retiree/Retired: _____
Subscriber/Child(ren)	\$	\$	\$	\$		Number of Waivers: _____
Family	\$	\$	\$	\$		Total Number of Eligibles: _____
% of Renewal Increase:						

New Hire Waiting Period: 30 Days 60 Days 90 Days Other: _____

- Please provide group claims experience and rate history for the past 36 months (200 eligibles or more).

C. Medical Profile

Serious Medical Conditions - As an employer are you aware of any employee or dependent of an employee, including those not enrolling for coverage, who has been diagnosed or treated for any of the following conditions? **Please mark the number of employees/dependents next to the appropriate condition.** Include additional details, if available, in space provided below or on the reverse side of this document.

#	Condition	#	Condition
	AIDS/ARC or Acquired Immune Deficiency Syndrome – Explain below		Liver Cirrhosis / Liver Disorders / Pancreas – Explain below
	Birth Abnormalities / Birth Injuries		Lupus – Explain below
	Blood Disorders, i.e. Hemophilia, Leukemia, etc. – Explain below		Mental Nervous Disorders / Mental Illness / Depression / Substance Abuse
	Cancer/Cancerous Tumor / Skin Cancer – Explain below		Multiple Sclerosis / Muscular Dystrophy
	Recovered: Yrs. Type:		Paralysis – Explain below
	Chest Pain/Congestive Heart Failure/Coronary Artery Disease/ Bypass – Explain below		Pregnancy Due Date:
	Chronic Obstructive Lung Disease, i.e. Emphysema, Bronchitis, etc. – Explain below		Stomach or Bowel Disorders, i.e. Ulcer / Crohn’s disease, Ulcerative colitis, etc.
	Diabetes – Type/Treatment:		Stroke (Cerebral)
	Epilepsy / Seizures – Type/Treatment:		Transplant (Done/Pending)Cornea/Liver/Kidney/Heart/Lung - Explain below
	Kidney Disorders/Kidney Stones/Polycystic Kidney Disease - Dialysis/Renal Failure – Explain below		Tumor, Cysts – Benign / Malignant – Explain below

- Are you aware of any other serious medical conditions, not listed above? Has any employee or dependent of an employee been hospitalized or received medical treatment within the past 12 months? If yes, explain below.
- Are there any employees, currently not actively at work or unable to perform their normal work duties due to a disability or work-related injury? If yes, explain below.

Describe or Answer Any Illness/Condition related Questions from Above

If additional space is needed to respond to any question, please provide response on separate page and attach.

To the best of my knowledge and belief, the answers to the above questions are true.

Group Signature: _____ Title: _____ Date: _____
 Broker: _____ Company: _____ Date: _____
 Sales Representative: _____ Date: _____