Group Questionnaire

Section 1: Group information

Group name			
City		State	ZIP code
Type of business	SIC code	How long in business	Requested effective date

Section 2: Prior carrier

Prior carrier 1				Period insured
Type of coverage	Type of plan	Employer contribution	Total number of employees	Total number of active employees eligible for benefits
Prior carrier 2				Period insured
Prior carrier 3				Period insured
Has the group/broker requested and/or received paid claims information from the current carrier within the last six months? ☐ Yes ☐ No If yes, please provide all claim information received.				

Section 3: Rates — Please include the current and renewal rates, or attach the renewal rates.

	Current plan	Rates effective (MM/DD/YY)	EE	ES	EC	EF
1						
2						
3						

	Prior plan	Rates effective (MM/DD/YY)	EE	ES	EC	EF
1						
2						
3						

Section 4: Risk

When answering questions on this enrollment application 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.

1. Has anyone received medical benefits exceeding $10,000 in the last 12 months? . . . . . ☐ Yes ☐ No
2. Do any employees, dependents or COBRA members currently have a disability? . . . . . ☐ Yes ☐ No
3. Are any employees or dependents pregnant? . . . . . ☐ Yes ☐ No
4. Have any employees missed more than 10 consecutive days of work in the last 12 months due to an illness or injury? . . ☐ Yes ☐ No
5. Are any employees, dependents or COBRA members currently hospitalized, or anticipating hospitalization or surgery in the next three months? . . . . . ☐ Yes ☐ No
6. Within the past 12 months, has any employee or dependent had a serious continuing claim (i.e., a chronic or ongoing condition likely to cost $10,000 or more per year for treatment) due to a mental or physical disorder? . . . . . ☐ Yes ☐ No

   If yes, please check the appropriate box(es) below.

☐ AIDS/Immune disorder	☐ Cardiovascular	☐ Infertility	☐ Neurological
☐ Alcohol abuse	☐ Diabetes	☐ Intestines	☐ Pancreas
☐ Arthritis	☐ Drug/Substance abuse	☐ Kidney	☐ Skin
☐ Back/Neck	☐ Epilepsy	☐ Liver	☐ Stomach
☐ Blood	☐ Ears/Eyes	☐ Lungs	☐ Stroke/Paralysis
☐ Bone/Joint	☐ Emphysema/Pulmonary	☐ Lupus	☐ Venereal
☐ Brain	☐ Heart disease	☐ Mental/Nervous	☐ Other (detail below)
☐ Cancer/Tumor	☐ High-risk pregnancy	☐ Migraines	

If you answered yes to one or more questions 1–6, please provide the following information for each individual with a likely serious condition.

Question number	EE/Dep age	Condition	Name(s) of medications	Date of last treatment (MM/DD/YY)	Claim amount	Current treatment prognosis
					$	
					$	
					$	
					$	
					$	

Section 5: Signatures required

Owner/officer/group administrator name	Title
Signature of owner/officer/group administrator X	Date (MM/DD/YY)
Broker name	Title
Signature of broker X	Date (MM/DD/YY)

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