



Group and Plan Information

Group Information	
Group Name:	Desired Effective Date:
Address:	City / ZIP/ County:
Phone:	Nature of Business:
Years in Business:	Fed Tax ID:
Total # of Full - time Employees:	% Participation:
Number of EE's residing Out of Area:	% Turn Over:
Location(s) with zip-code:	Number of COBRA Enrollees:
Current Health Carrier:	How long?
Employer Contribution (Medical): Employee	Dependent
Employer Contribution(Dental): Employee	Dependent
Waiting Period:	Previous Carriers (5 years):

Medical Rates and Plan Information					
Plan 1	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)
Renewal					
Current					
Prior					
Plan 2	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)
Renewal					
Current					
Prior					
Plan 3	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Description (Carrier, effective date, deductible, coinsurance, HDHP, etc.)
Renewal					
Current					
Prior					
Health & Wellness Initiatives				Date of Last Health Fair:	Years In Place:

Dental Rates and Plan Information					
Plan 1	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Description
Renewal					
Current					
Prior					
Plan 2	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Description
Renewal					
Current					
Prior					

Additional Information
Client Notes: (Please share any additional information that you would like the underwriter to know)



Required for all Groups

Group Risk Evaluation

Group Name

Questionnaire

1. Have covered employees or dependents ever had, consulted a health care professional, or received counseling or treatment for:(Circle all that apply and explain below)?

AIDS / HIV	Heart Disease	Multiple Sclerosis
Alcohol/Substance abuse	Hodgkin's Disease / Lymphoma	Muscular Dystrophy
Blood Disorders	Hypertension	Nervous System / Muscular
Cancer	Infertility	Organ Disorder
Cerebral Palsy	Kidney / Urinary	Rheumatoid Arthritis
Colitis	Leukemia	Sarcoidosis
Crohn's Disease	Liver	Sexually Transmitted Diseases
Diabetes	Lung	Strokes
Digestive System	Lupus	Transplants
Emphysema	Mental / Emotional	Tumors

2. Are any employees or dependents currently pregnant? If so, list the expected delivery date, and any complications including the anticipation of multiple births or C-section? Yes No
3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 5 years? Yes No
4. Have any employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years? Yes No
5. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months? Yes No
6. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare? Yes No

Additional Details

For any question above answered "Yes", please complete the following:

Question #	Employee or dependent Age & Gender	List condition, disorder, disease, problem and treatment	Dates of care: first / last due date if pregnant	Cost of care: actual or expected	Health status

Signature

I certify to the best of my knowledge that the above information is true, complete and accurate and acknowledge that any coverage issued by the Plan will be issued in reliance thereon.

Employer Signature	Title	Date
Agent Signature	Agency	Date

