Group and Plan Information

Group Information	
Group Name:	Desired Effective Date:
Address:	City / ZIP / County:
Phone:	SIC Code / Nature of Business:
Years in Business:	Fed Tax ID:
Total # of Eligible 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?
Waiting Period:	Previous Carriers (5 years):
Employer Contribution (Medical): Employee	Dependent
Employer Contribution(Dental): Employee	Dependent

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)

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:(Select all that apply and explain below)?

AIDS / HIV	☐	Emphysema	☐	Mental / Emotional	☐
Alcohol/Substance abuse	☐	Heart Disease	☐	Multiple Sclerosis	☐
Auto Immune Disease	☐	Hodgkin's Disease / Lymphoma	☐	Muscular Dystrophy	☐
Blood Disorders	☐	Hypertension	☐	Nervous System / Muscular	☐
Cancer (include type)	☐	Infertility	☐	Organ Disorder	☐
Cerebral Palsy	☐	Kidney / Urinary	☐	Rheumatoid Arthritis	☐
Colitis, Crohn's, Diverticulitis	☐	Leukemia	☐	Sarcoidosis	☐
Cystic Fibrosis	☐	Liver including Hepatitis	☐	Strokes	☐
Diabetes	☐	Lung	☐	Transplants	☐
Digestive System	☐	Lupus	☐	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 condition selected or question above answered "Yes", please complete the following:

Question #	Age & Sex	List condition, disorder, or disease	Dates of care or due date if pregnant	Treatment / Prognosis	Ongoing Y / N	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

Individual Health Questionnaire

Employee Information									
Group Name:						Are you planning to enroll in your employer's health insurance plan?		If not, do you have other coverage?	
Home Zip Code:	Job Title:								
Relationship	Full Name	Date of Birth (mm/dd/yyyy)	Sex (M/F)	Height (ft./in.)	Weight (lbs.)	YES	NO	YES	NO
Employee						☐	☐	☐	☐
Spouse						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐
Child						☐	☐	☐	☐

Health Information

Are you or your dependents afflicted or diagnosed with a major disease or illness? (If yes, explain below)	YES ☐	NO ☐
Please list any of the following: AIDS/HIV, Substance Abuse, Blood Disorders, Cancer (include type), Congenital Disorders, COPD, Cystic Fibrosis, Diabetes, Digestive System (including Crohn's and Colitis), Heart Disease, Kidney Disease, Liver Disease (Hepatitis), Lung Conditions, Pregnancy (including any anticipated complications), Transplants (include type), Multiple Sclerosis, Rheumatoid Arthritis or other major illnesses.		
Are you or your dependents anticipating any medical or surgical treatment in the next year? (If yes, explain below)	YES ☐	NO ☐
Do you or your dependents currently take any prescription medication? (If yes, explain below)	YES ☐	NO ☐
Have you or your dependents used any type of tobacco product within the past 5 years? (If yes, explain below)	YES ☐	NO ☐

Health Information (Please use the back of the form if needed)

Individual Name	Date (First / Last)		Diagnosis	Prognosis	Expense

Prescription Medication Information (Please use the back of the form if needed)

Individual Name	Date (First / Last)		Name and Dosage of Medication	Reason for Medication	Expense

Signature

I certify that the information stated above is true and correct and acknowledge that any coverage issued by the Plan will be issued in reliance thereon.

Employee Signature	Date