Employer Group Health Questionnaire

This questionnaire is designed to provide information specific to your group and will be used in evaluating the risk characteristics to more accurately establish rates, benefits and eligibility rules as part of your application for coverage.

I. GENERAL INFORMATION

Company Name:_____

Contact Person:_____

Billing Contact Person:_____

Billing Contact Email:_____

Home Office Address: _____

City:_____ State:_____ Zip:_____

Phone Number:_____ # of Years In Operation:_____

Type of Business:_____

Standard Industry Code (SIC):_____ Federal Tax ID#:_____

Requested Effective Date:_____

II. GROUP DATA

1. Total Employees: Full-Time _____ Part-Time _____ COBRA _____
2. Total Eligible Employees: _____ Total Employees Waiving Coverage: _____
3. Employer Contribution: Employee _____ Dependent _____
4. Waiting Period For New Hires:
   - ☐ Effective date is 1st of month following date of hire
   - ☐ Effective date is 1st of month following 1 month of continuous employment
   - ☐ Effective date is 1st of month following 2 months of continuous employment
   - ☐ Effective date is 1st of month following 3 months of continuous employment

5. If there are locations other than indicated above, please provide the following details:

City	State	Zip	# of EE'S

6. Are all eligible employees covered by Workers Compensation? ☐ Yes ☐ No
   If no, please explain: _____

III. PLAN INFORMATION

1. Please list all health carriers for the past 5 years:

Carrier	From	To	Reason for Termination

2. Please provide current and renewal rates for all plan(s) currently offered:

Plan 1 (Please Provide Plan Details): _____

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

Plan 2 (Please Provide Plan Details): _____

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

Plan 3 (Please Provide Plan Details): _____

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

IV. ADDITIONAL INFORMATION REQUIRED

1. **Census** – Attach a current census which includes: Date of birth, Gender, Home zip code, Enrollment tier, Current plan selection (if more than one plan is offered), and active. COBRA/retiree status.
2. **Benefit Plan Summaries** – Please provide current benefit summaries.
3. **Statements of Health (Only if Claim information is not available) -** Attach a Health+ Group Health and Dental application for each eligible employee (including those on state continuation or COBRA), including his/her covered dependents.
4. **Claim and Enrollment Experience (Current plan year and past two plan years if available from carrier)**
   - Paid claim reports for current plan year and past two plan years
     - Lists the claims paid by month, quarter or annually.
   - Large claimant reports for current plan year and past two plan years (if available from carrier)
     - Lists the participants with large paid claims (usually in excess of $10,000)
     - Detail needed for participants on current large claimant report - (if known):
       - Medical condition (diagnosis)
       - Is treatment complete or ongoing?
       - Date of service (month and year) that large portion of the medical services were rendered. (For example the month and year of the surgery, accident, etc…)

- Enrollment history - Lists the enrollment counts by month, quarter or average for the plan year (if available from carrier)

5. **State Wage and Tax Statement** – Attach a copy of your most recent state wage and tax statement.
6. **Current Bill** – Attach a copy of the most recent monthly bill from your current carrier.
7. **Self Funded Groups Only** (**Self funded groups do not need to provide Current Bill and State Wage and Tax Statement.)** Please provide the following Claim information:
   - Aggregate report from the carrier - current plan year and past two plan years
     - Lists the claims paid by month and enrollment by month
   - Specific report from the carrier – current plan year and past two plan years
     - List the participants with paid claims in excess of 50% of the specific deductible
     - Detail needed for participants on current specific report - (if known):
       - Medical condition (diagnosis)
       - If treatment is complete or ongoing
       - Date of service (month and year) that large portion of the medical services were rendered. (For example the month and year of the surgery, accident, etc…)

   Stop Loss Information (Current plan year and past two plan years)
   - Specific Stop Loss Coverage
     - Single and family monthly specific premium
     - Contract type (Paid, 24/12, 18/12, 15/12, etc…)
     - Is prescription drug coverage currently covered under the specific contract?
   - Aggregate Stop Loss Coverage
     - Aggregate monthly premium
     - Monthly claim factors
     - Contract type
     - Is prescription drug coverage currently covered in the aggregate contract?
8. **Health+ Disclosure Statement –** Groups not submitting individual applications need to complete in full and sign (see attached).

V. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in this Employer Group Health Questionnaire is complete and accurate to the best of my knowledge.

Signature: _____
(Signature of Company Executive or Senior Human Resource Employee)

Date Signed: _____

Print Name: _____

Title: _____

Phone #: _____