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Group Health Questionnaire

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable, the questionnaire cannot be processed if incomplete and please use additional paper if necessary.

Date: Proposed Effective Date:

I. Company and Current Enrollment Information

Company Name:

Street Address:

City: State: Zip: County:

Benefits Contact & Phone #:

Total Number of employees on payroll:

Total Full Time: Total Part Time:

Total Number of employees currently enrolled in health care plan:

Are any health plan enrollees NOT paid employees (other than spouses or children)? Yes No

*** If yes, please provide names and details:

Current Health Carrier: Health Carrier Renewal Date:

Is your current Plan Self-Funded? Yes No Don't Know *** If yes, please provide claims.

Are you currently with a PEO? Yes No If yes, name of PEO:

Any ineligible class of employees: Yes No If yes, which class:

Please provide a complete description of your business operations:

SIC Code:

Number of Locations: Please identify all states of operations:

Five Year Prior Group Medical Insurer & Effective Date:

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Reason for Cancellation

Has your group been declined for coverage during the last 12 months? Yes No

If yes, provide details

A. List any current COBRA / State Continuation participants None

Name / DOB / Phone # of Individual Date Eligible Activating Event / Date

B. List any participants currently eligible for COBRA who have not yet elected coverage and/or any participant who will become eligible for COBRA prior to the Health Plan effective date: None

Name / DOB / Phone # of Individual Date Eligible Activating Event / Date

C. Did any employee, dependent or COBRA participants incur over $5,000 in claims in the last 12 months?

Yes No

D. Have any employees, dependents or COBRA participants been diagnosed or treated for the following conditions (pre-existing conditions): Cancer, Blood Disorders, Stomach Disorder Psychological, Alcohol / Drug Abuse, Heart Conditions, Back Problems, Multiple Sclerosis, Muscular, Diabetes, AIDS or Other. If so, provide details of each.

II. Current Plan Contribution Information

(Does your company have more than one Contribution Level? If so, please list each separately)

Employee

Only Employee + Spouse Employee + Child Family

Company Contribution Levels ($ or %)

Company Contribution Levels ($ or %)

III. Rate History & Plan Design Details (include the 3 most elected plans)

Plan 1 Name:

Enrolled:

Renewal Rates (effective date)

Most recent

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12 Months 13-24 Months Prior HMO

PPO

HDHP

POS

		Premium Rates			Plan Design Details	
Employee Only	#	$	$	$	Annual Deductible	$
Co-Insurance	%					
Out of-Pocket Max	$					
Office Visit Copay	$					
Prescription Drugs	___/___/___					
Employee + Spouse	#	$	$	$		
Employee + Child(ren)	#	$	$	$		
Employee + Family	#	$	$	$		

Plan 2 Name & other plans ,if any:

Enrolled:

Renewal Rates

(eff.):

Most recent

12 Months 13-24 Months Prior

HMO

PPO

HDHP

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POS

	Premium Rates			Plan Design Details	
Employee Only #	$	$	$	Annual Deductible	$
Co-Insurance %					
Out of-pocket Max $					
Office Visit Copay $					
Prescription Drugs ___/___/___					
Employee + Spouse #	$	$	$		
Employee + Child(ren) #	$	$	$		
Employee + Family #	$	$	$		

IV. Group Medical History

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). This information will be used to evaluate medical risk, not eligibility for individual coverage. The Health Insurance Portability and Accountability Act ("HIPAA") prohibits group health insurance issuers from establishing rules for eligibility on the basis of health factors. Health factors are defined as: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, and disability.

Yes No Within the past 12 months have any employees or their dependents been diagnosed or treated for any of the conditions below? Please circle the ones which apply:

ARC or AIDS	Diabetes	Immune System	Neurological
Alcohol Abuse	Drug/Substance Abuse	Infertility	Pancreas

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Arthritis	Enlarged Lymph Nodes	Intestines	Skin
Back, Neck	Epilepsy	Kidney	Stomach
Blood	Ears/Eyes	Liver	Stroke/Paralysis
Bone/Joint	Emphysema/Pulmonary	Lungs	Transplants
Brain	Growth Disorders	Lupus	Vascular Disease
Cancer/Tumor	Heart Disease	Mental/Nervous	Venereal
Cardiovascular	High Risk Pregnancies	Migraines	Other, Detail Below

V. Serious Illness / Conditions Questions:

A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? To the Best of My Knowledge

Yes No

B. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?

Yes No

C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalized is necessary?

(If yes to any, please provide details in the table below.)

Yes No

Name	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

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E. List any employees and/or dependents who are on the health plan that are disabled:

None

Name Disability Qualifying Event

Is anyone Currently Pregnant? If yes, please provide due date and note below if normal, high risk, multiple birth, or preterm labor with this pregnancy.

This includes employees, dependents or COBRA participants To the Best of My Knowledge

Yes No

In the event that information has been omitted or is inaccurate, the insurance carrier may deny or limit coverage for an employee and PEO may terminate any service agreement for breach. In such cases, the client may be liable to PEO or an employee for any damages.

PEO gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight.

Because actuarial analysis requires current, accurate information, this questionnaire expires after 60 days from the date signed below. After that time, a new questionnaire will be required.

I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify PEO of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage with PEO.

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PEO Program Notice of Privacy Practices provides more detailed information about how the PEO Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The PEO Program and my health plan are not required by law to grant my request. However, if my request is granted, the PEO Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the PEO Program or my health plan have already used or disclosed my protected health information in reliance upon my consent.

Authorized Signature Title Date

Print Name Print name of Company

Broker/Sales Signature Broker /Sales Print Name Date