



BENEFITS UNDERWRITING QUESTIONNAIRE

Company Name: _____

1. Number of Full-Time EE's: _____ Number Eligible for Health Coverage: _____ Number of Participants: _____

2. Current Insurance Carrier or PEO: _____ Eff. Date: _____ Renewal Date: _____

3. Type of Coverage (please circle): HMO POS PPO HDHP

4. Please indicate your current and renewal rates below (*if this is not your renewal period, include last year's rates instead*):

Current Rates: Employee \$ _____ EE+SP \$ _____ EE+CH \$ _____ Family \$ _____

Renewal Rates: Employee \$ _____ EE+SP \$ _____ EE+CH \$ _____ Family \$ _____

5. Please answer the following questions to the best of your knowledge. *Please do not disclose the name of any employee or dependent.* Give details to "yes" answers below. Use additional sheets if necessary.

- | | <u>YES</u> | <u>NO</u> |
|--|--------------------------|--------------------------|
| a) Are any employees or dependents currently pregnant? If yes, what trimester? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Are any of the employees currently disabled, hospitalized or not actively at work? | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Did any employee, dependent or COBRA participants incur over \$5,000 in claims in the last 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Do any employees or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary? | <input type="checkbox"/> | <input type="checkbox"/> |
| e) Has the company received a <i>Decline to Quote</i> from any carrier or PEO in the past 3 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Have any employees, dependents or COBRA participants been diagnosed or treated for the following conditions (pre-existing conditions)? | | |

- | | | | |
|-----------------------------|------------------------|------------------------|--------------------------|
| _____ Cancer (Last 5 years) | _____ Blood Disorders | _____ Stomach Disorder | _____ Psychological |
| _____ Alcohol / Drug Abuse | _____ Heart Conditions | _____ Back Problems | _____ Multiple Sclerosis |
| _____ Muscular Dystrophy | _____ Diabetes | _____ AIDS | Other _____ |

If you answered 'YES' to any of the above questions, please explain in detail below:

| Name of Condition | Date of Diagnosis (mm/yy) | Treatment / Medication |
|-------------------|---------------------------|------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

6. Has any employee enrolled in COBRA? _____ (If yes, please list below)

| Employee Name | Event Date | Coverage Level (ee, family) | Plan Type (HMO, PPO) |
|---------------|------------|-----------------------------|----------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

7. Do any employees reside in another state or region? _____ (If yes, please list below)

| Employee Name | Dependent Name | City / Zip Code |
|---------------|----------------|-----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I undersigned hereby certifies that the information in this Medical Questionnaire is correct. In the event that information has been omitted, the insurance carrier may deny or limit coverage for an employee. I certify that all answers and 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 any insurance coverage.

PROSPECTIVE CLIENT

Signature: _____ Date: _____