Group Health Questionnaire (page 1 of 5)

This questionnaire must be filled out completely. P lease be sure to indicate "None" if applicable. PEO Match will not accept t he questionnaire if incomplete. 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 operation:					**SIC Code:**
Number of Locations: _______		**Please identify all states of operation: ____________________**			

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A. List any <u>Current</u> <u>Participants</u> in COBRA / State Continuation (use additional paper if necessary):

❑ **NONE**

Name & DOB	COBRA / Continuation Effective Date	Activating Event & Date (i.e. employee termination, etc.)

B. List any participants currently <u>Eligible</u> for COBRA who have *not* yet *elected* coverage and/or any participants who *will become eligible* for COBRA prior to the Health Plan effective date (use additional paper if necessary):

❑ **NONE**

Name & DOB	Date Eligible	Activating Event & Date

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

❑ **NONE**

Name & DOB	Disability	Qualifying Event

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II. RATE HISTORY	(if more than 3 plans, include the 3 most popularly-elected plans)			
Plan 1 Name: ______________	# Enrolled: ___________	Renewal Rates (eff.__/__/____)	Most recent 12 months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 2 Name: ______________	# Enrolled: ___________	Renewal Rates (eff.__/__/____)	Most recent 12 months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 3 Name: ______________	# Enrolled:	Renewal Rates (eff.__/__/____)	Most recent 12 months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION	(Individual, in-network only)		
Current Plan Names:	1:	2:	3:
Current Plan Types:	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______
Annual Deductible			
Co-Insurance (as %)			
Out-of-Pocket Max (excluding deductible)			
Office Visit Copay			
Prescription Drug Copay generic / brand formulary / brand non-formulary	/ /	/ /	/ /

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (by $ or %)				

- **Attach a copy of your benefit summary for each plan and year listed above.**
- **Include carrier claims report if available.**

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Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

GENERAL ILLNESS QUESTIONS:	To the Best of My Knowledge (any or all):
a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability? c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? ***(If yes to any or all, please provide details in the table below.)***	❑ YES ❑ NO

SPECIFIC ILLNESS QUESTION:

Is anyone currently being treated or been advised to seek treatment for any of the following?

Please check all that apply:

- ❑ AIDS or testing HIV Positive
- ❑ arthritis
- ❑ back disorder
- ❑ cancer
- ❑ diabetes
- ❑ heart disease
- ❑ kidney disorder
- ❑ liver disease
- ❑ mental illness
- ❑ muscular disorder
- ❑ nervous system disorders
- ❑ respiratory disease
- ❑ stroke
- ❑ substance dependency
- ❑ transplants
- ❑ tumor
- ❑ other serious conditions

(If any boxes are checked, please provide details in the table below.)

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

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Known Medical Conditions <u>to the best of your knowledge</u> (continued):

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
Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

Authorized Signature ____________________ **Title** ____________________ **Date** __________

Print Name ____________________ **Print Name of Company** ____________________

____________________ ____________________ __________

Broker / Sales Signature **Broker / Sales Print Name** **Date**