PREFERRED RISK ADMINISTRATORS
YOUR COMPANY - AMPLIFIED

EMPLOYER HEALTH QUESTIONNAIRE
For Self-Funded Health Plans

General Information (PLEASE PRINT)			
Legal Group Name		Federal Tax ID Number	
Company Contact		Title	
Phone Number	Fax Number	Email Address	
Company Address	City	State	Zip

General Questions				
1. Total number of eligible employees.	2. Total number of employees enrolling in group coverage.			
3. Name of current carrier and plan offered.	4. How long has your company been insured by your current health insurance carrier?			
5. The anniversary date of current plan.	Month	Day	Year	
6. Are all eligible employees covered by Worker's Compensation?	☐ Yes	☐ No		
7. Are any enrolling employees or dependents totally disabled?	☐ Yes	☐ No	If Yes, please explain:	
Name	Age	Date of Disability	mo/day/yr	
Name	Age	Date of Disability	mo/day/yr	
8. Has this employer ever been covered by a Preferred Risk plan before?	☐ Yes	☐ No		
If Yes, dates of coverage: mo/day/yr				

Current/Renewal Rates Needed

Please provide the following information or attach a copy of your current rates and/or the most recent renewal.

TIER	PRIOR YEAR RATES	CURRENT RATES	RENEWAL RATES
Subscriber Subscriber/Child			
Subscriber/Children			
Subscriber/Spouse			
Family			

Have any eligible employees/dependents/ or COBRA participants been treated or expect to be treated for any of the following conditions?					
Please check the appropriate box beside the condition and if yes, provide details below:					
	Yes	**No**		**Yes**	**No**
HIV			Multiple Sclerosis (MS)		
Cancer			Heart or Vascular Disease		
Stroke			Alcohol or Substance Abuse		
Diabetes			Respiratory Disease/Disorder		
Epilepsy			Disease/Disorder of Spine or Back		
Organ Transplant			Connective Tissue Disease (Lupus)		
Bladder Disease/Disorder			Liver Disorder (Hepatitis/Cirrhosis)		
Kidney Disease/Disorder			Nervous/Mental or Psychological Disorder		
Stomach/Intestinal Disorder			Acquired Immune Deficiency Syndrome (AIDS)		

Details: _____

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(If more room is needed, please attach additional documentation)

Have any employees, dependents of COBRA participants to be covered		
1. Had medical claims that exceeded $5,000 in the last 24 months for any illness, injury or hospitalization?	□ Yes □ No	If Yes, please explain:
2. Been hospitalized within the past five years?	□ Yes □ No	If Yes, please explain:
3. Been advised to have an operation or had an operation within the past five years?	□ Yes □ No	If Yes, please explain:

Employer Certification

I, the undersigned, certify that all of the information shown on this Employer Group Health Questionnaire is true and accurate to the best of my knowledge. It is understood that omission of information on the questionnaire, whether intentional or unintentional, may result in the invalidation of coverage, if in Preferred Risk Administrators' sole judgment, the omitted information was, material to the group's rate determination.

_____ _____

Please Print Name **Title**

_____ _____

Authorized Signature **Date Signed *(Month, Day, Year)***

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