



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

<b>General Questions</b>				
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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
7. Are any enrolling employees or dependents totally disabled?		<input type="checkbox"/> Yes	<input type="checkbox"/> 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?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If Yes, dates of coverage: mo/day/yr				

<b>Current/Renewal Rates Needed</b>			
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:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please explain:
2. Been hospitalized within the past five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes, please explain:
3. Been advised to have an operation or had an operation within the past five years?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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)**