

Group Health Questionnaire

To be Completed by Employer to Receive Benefits and Rate Proposal



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When explaining answers, please give details, including names, dates and diagnosis where appropriate. Attach additional pages of explanation if necessary.

1. To the best of your knowledge, has any employee or dependent incurred health claims exceeding \$5,000 in the last 3 years for the conditions below?

- | | | | | |
|---|--|---|------------|-----------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Cystic Fibrosis | YES | NO |
| <input type="checkbox"/> Circulatory Disorders/Stroke | <input type="checkbox"/> Growth Hormone | <input type="checkbox"/> Heart Conditions | | |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lupus | <input type="checkbox"/> Kidney Disorder/Dialysis | | |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Liver | <input type="checkbox"/> Respiratory Disorders | | |
| <input type="checkbox"/> Neurological Disorders | <input type="checkbox"/> Paralysis | <input type="checkbox"/> Transplants | | |
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Organ/Tissue | <input type="checkbox"/> Cancer/Leukemia/Hodgkin's Disease/Tumors | | |
| <input type="checkbox"/> Premature Birth/Congenital Birth Defects | | <input type="checkbox"/> Rheumatoid Arthritis | | |
| <input type="checkbox"/> Mental Disorder/Chemical Dependency | | <input type="checkbox"/> Multiple Sclerosis | | |

IF YES, please explain _____

2. Is there any employee or dependent that has been admitted within the last 24 months, is currently admitted, or is anticipating admission to a hospital, nursing home or other medical facility for treatment? **YES** **NO**

Is there any employee currently off work for any reason?

IF YES, please explain _____

3. Are any employees or dependents pregnant? If **YES**, please provide due date of child, if multiple birth and/or high risk. **YES** **NO**

4. Are all employees covered by worker's compensation? If **NO**, please explain. **YES** **NO**

Employer's Statement

The information on this form is an accurate reflection of our current status. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Name of Employer _____ Title _____

Signature _____ Date _____