# Group Health Questionnaire (page 1 of 6)

**Fields marked with an asterisk "*" are required**

**This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. Group Benefit Services will not accept the 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:**<br>***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**<br>***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**<br>***If yes, name of PEO:** | | ***Any ineligible class of employees □Yes □No**<br>**If yes, which class:** | | | |
| **Please provide a complete description of your business operation:** | | | | **SIC Code:** | |
| ***Number of Locations: _____** | | ***Please identify all states of operation: _____** | | | |
| ***Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company, or a PEO? □Yes □No**<br>***If yes, please briefly explain the reason why and when this occurred:** | | | | | |

# **Group Health Questionnaire** (page 2 of 6)

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

❑ **NONE**

| Name of Individual | COBRA / Continuation Effective Date | Activating Event / Date (i.e. employee termination, etc.) |
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**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 | Date Eligible | Activating Event/Date |
|---|---|---|
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**C. List any employees and/or dependents who are on the health plan that are disabled:**

❑ **NONE**

| Name | Disability | Qualifying Event |
|---|---|---|
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# **Group Health Questionnaire** (page 3 of 6)

| **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 %)** | | | | |

# **Group Health Questionnaire** (page 4 of 6)

**Next, please answer the following questions on behalf of your company <u>to the best of your knowledge</u>. 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?<br><br>b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?<br><br>c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?<br><br>***(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?

*<u>Please check all that apply</u>:

| | | |
|---|---|---|
| ❑ AIDS or testing HIV Positive | ❑ kidney disorder | ❑ stroke |
| ❑ arthritis | ❑ liver disease | ❑ substance dependency |
| ❑ back disorder | ❑ mental illness | ❑ transplants |
| ❑ cancer | ❑ muscular disorder | ❑ tumor |
| ❑ diabetes | ❑ nervous system disorders | |
| ❑ heart disease | ❑ respiratory disease | ❑ 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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# **Group Health Questionnaire** (page 5 of 6)

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

| *IS ANYONE CURRENTLY PREGNANT?<br>If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy.<br>*This includes employees, dependents or COBRA participants.* | *To the Best of My Knowledge:<br>❑ YES ❑ NO |
|---|---|

| Name | Due Date | Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.) |
|---|---|---|
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# **Group Health Questionnaire** (page 6 of 6)

I certify that the statements herein are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify the entity collecting this information of any changes that occur after signing this Group Health Questionnaire and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement may be terminated for breach. In such cases, my company may be liable to Milliman or an employee for damages.

This information is gathered for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

| | | |
|---|---|---|
| ***Authorized Signature** | ***Title** | ***Date** |
| ***Print Name** | ***Print Name of Company** | |
| **Broker / Sales Signature** | **Broker / Sales Print Name** | **Date** |

**Client Privacy Notification**

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detail health information (protected health information) that you provide via hard copy or through the Milliman, Inc. HERO Online Data Collection Website will be used solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), association group (Association) or Trust that will provide a health insurance quote to the employer. Milliman is acting as a Business Associate to the PEO/MEWA/Association/Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations. Milliman will not sell, license, transmit or disclose this information outside of Milliman unless: a) necessary for Milliman to provide the services on behalf of the PEO/MEWA/Association/Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.