

**Group Health Questionnaire** (page 1 of 5)

**This questionnaire must be filled out completely. Please be sure to indicate “None” if applicable. Modern Business Associates will not accept the questionnaire if incomplete. Use additional paper if necessary.**

**Date** **Proposed Effective Date:**

|  |
| --- |
| 1. **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:** **Current Medical plan:** [ ]  Stand alone [ ]  PEO Master Plan | **Health Carrier Renewal Date:** (mo/day/yr)  |
| **Is your current Plan Self-Funded?** **[ ]  Yes** **[ ]  No** **[ ]  Don’t Know****\*\*\*If yes, please provide claims.** **[ ] Attached** |
| **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 current participants 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 eligible 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

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| --- | --- | --- |
| **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

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| **Name** | **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  | #       | $       | $       | $       |

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| **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  | #       | $       | $       | $       |

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| **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  | #       | $       | $       | $       |

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| **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 |       |       |       |

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

**[ ]  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.**

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| **GENERAL ILLNESS QUESTIONS:**1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?
2. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?
3. Has anyone been advised hat medical treatment, diagnostic testing, surgery or hospitalization is necessary?
 | To the Best of My Knowledge(any or all):[ ]  YES [ ]  NO**If yes to any or all, please provide details in the table below.** |

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| **SPECIFIC ILLNESS QUESTION:**Is anyone currently being treated or been advised to seek treatment for any of the following? **(If any or all are checked, please provide details in the table below.)****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 |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **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 5)**

**Known Medical Conditions to the best of your knowledge (continued):**

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| **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(any or all):[ ]  YES [ ]  NO |
| **Name** | **Due Date** | **Type of Pregnancy or Condition****(check all that apply)** |
|       |       | [ ]  Normal [ ]  high risk [ ]  preterm [ ]  multiple birth |
|  |       | [ ]  Normal [ ]  high risk [ ]  preterm [ ]  multiple birth |
|  |       | [ ]  Normal [ ]  high risk [ ]  preterm [ ]  multiple birth |
|  |       | [ ]  Normal [ ]  high risk [ ]  preterm [ ]  multiple birth |

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| I certify that the statements 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 Modern Business Associates of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage. In the event that material information has been omitted or is inaccurate, the insurance carrier may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, Modern Business Associates service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that Modern Business Associates also may adjust my insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation. Modern Business Associates gathers this information 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. Prospective employees in Michigan should not provide information regarding height or weight. Modern Business Associates Program Notice of Privacy Practices provides more detailed information about how Modern Business Associates Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. Modern Business Associates Program and my health plan are not required by law to grant my request. However, if my request is granted, Modern Business Associates Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent Modern Business Associates Program or my health plan have already used or disclosed my protected health information in reliance upon my consent. *Information disclosed on this form is considered valid for effective dates within 90 days of date signed. I will notify Modern Business Associates of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage. I understand that Modern Business Associates reserves the right to re-underwrite based on a change in the Census or Demographics*  |
|              |
| **Authorized Signature (Must Sign) Title Date** |
| **Print Name Print Name of Company**  |
| **Broker/Sales Signature Broker/Sales Print Name Date** |