Company Legal Name

Company DBA*

*if applicable

Group Health Questionnaire
Please complete all information requested below. This questionnaire may not be accepted if incomplete. Select 'None' or note 'N/A' wherever applicable. Attach additional pages if more space is needed.

Company Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Phone Number

Please enter a valid phone number.

Benefit Contact Name

First Name

Last Name

In which states do your employees reside?

Total Full-Time Employees

Total Part-Time Employees

Total 1099 Employees on Payroll

Are you currently utilizing a PEO? If Yes, name of PEO?

Current Health Care Provider(s)

*If applicable

Health Care Renewal Date

*If applicable

Last Renewal Change %

*If applicable

Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company, or another PEO?

- ○ Yes
- ○ No

If 'Yes' please provide a brief explanation for the reason(s) as to why, and when this occurred

COBRA Information
List all CURRENT active participants in COBRA/State Continuation: (check 'No' if not applicable)

Do you have any active COBRA participants?

- ◯ Yes
- ◯ No

If 'Yes' Please list their: Name, Date of Birth, Home Zip Code, and COBRA Effective Date

*If applicable

Do you have any active COBRA 'eligible' former employees who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the proposed health plan effective date?

- ◯ Yes
- ◯ No

If 'Yes' Please list their: Name, Date of Birth, Home Zip Code, and COBRA Date Eligible & Activating Event

*If applicable

Do you have any Employees and/or dependents that are currently enrolled in health plans that are disabled or on FMLA or any type of medical leave?

- ◯ Yes
- ◯ No

General Employer Questions
Please answer the following questions to the best of your knowledge:

If 'Yes' Please list their: Name, Date of Birth, Home Zip Code, and Effective Date

*If applicable

Has anyone been treated for a serious illness, been hospitalized, or had surgery in the past 5 years?

- ○ Yes
- ○ No

Is anyone currently enrolled in the health plan currently hospitalized, in a treatment facility, incapacitated, and/or incapable of self-support due to a physical or mental disability?

- ○ Yes
- ○ No

Has anyone been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary?

- ○ Yes
- ○ No

Is anyone currently being treated or been advised to seek treatment for any of the following? (check all that apply)

- ☐ AIDS or HIV+
- ☐ Arthritis
- ☐ Back Disorder
- ☐ Cancer
- ☐ Kidney Disorder
- ☐ Liver Disease
- ☐ Muscular Disorder
- ☐ Nervous System Disorder
- ☐ Stroke
- ☐ Transplant(s)
- ☐ Tumor
- ☐ Heart Disorder
- ☐ Substance Dependency
- ☐ Mental Illness

☐

Respiratory Disease

- [ ] Diabetes
- [ ] Other

If "Other" please specify:

If you answered 'Yes' to any of the questions above in 'General Employer Questions,' Please provide the following answer: Currently Employed, Gender, Condition, Date of Onset, Date Last Treated, Treatment Drug, Degree of Recovery %

*If applicable

Are any employees, dependents, or COBRA active/eligible currently pregnant?

- ○ Yes
- ○ No

If 'Yes' Please list their Due Date, and Type of Pregnancy (Normal, High-Risk, Pre-Term, etc.)

Submitted By:

First Name Last Name