Group Employer Questionnaire

This questionnaire must be filled out completely, Please be sure to indicate "None" if applicable
The Plan will not accept the questionnaire 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: Contact Phone #: Email Address:			
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:		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 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: _____			

Broker #_____

Group Employer Questionnaire

A. List any <u>current 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.)

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

C. List any employees and/or dependents who are on the health plan that are disabled:

☐ **NONE**

Name	Disability	Qualifying Event

Group Employer Questionnaire

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 %)				

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 The Plan of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with The Plan.

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, The Plan service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that The Plan also may adjust my insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation.

The Plan 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.

The Plan Notice of Privacy Practices provides more detailed information about how The Plan 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. The Plan and my health plan are not required by law to grant my request. However, if my request is granted, The Plan and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent The Plan 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 The Plan of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with The Plan. I understand that The Plan reserves the right to re-underwrite based on a change in the Census or Demographics.

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