



Employer Group Name _____

Please answer the following on behalf of all proposed insured's (eligible employees and their eligible dependents, retirees, continuees on COBRA or other continuation; and individuals who are eligible for, but have not yet elected, COBRA or another continuation program). If you need additional space, please check here and attach a separate sheet.

QUESTION 1: COVERAGE CONTINUATION – PLEASE ANSWER FOR ALL PROPOSED INSURED.

A) How many are currently on extension/continuation of benefits under COBRA / another program? <input type="checkbox"/> None <input type="checkbox"/> _____ - Complete table below.					
B) How many experienced a Qualifying Event within the past 90 days, or otherwise have become eligible to continue coverage under COBRA or another program? <input type="checkbox"/> None <input type="checkbox"/> _____ - Complete table below.					
Proposed Insured's Name	Age	Gender	Employee or Dependent	Date Continuation Began	Qualifying Event
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> E <input type="checkbox"/> D	/ /	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> E <input type="checkbox"/> D	/ /	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> E <input type="checkbox"/> D	/ /	

QUESTION 2: TREATMENT & CONDITION INFORMATION

To the best of your knowledge, are you aware of any employee, dependent or other individual on COBRA or other continuation of coverage:	Yes / No
A) Having been diagnosed or treated for any of the following conditions in the past 3 years? a) Cardiac disorder e) Respiratory disorder i) Psychological disorders b) Cancer (any form) f) Liver disorder j) Neuromuscular disorder c) Diabetes g) AIDS/Immune system disorder k) Transplant candidate d) Kidney disorder h) Alcohol/Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N
B) Who is currently disabled or receiving ongoing care for a medical disability?	<input type="checkbox"/> Y <input type="checkbox"/> N
C) Who is currently hospitalized or who is anticipating hospitalization or surgery within the next 60 days?	<input type="checkbox"/> Y <input type="checkbox"/> N
D) Who has missed more than 10 consecutive days of work in the past 12 months due to illness or injury?	<input type="checkbox"/> Y <input type="checkbox"/> N
E) Who is currently pregnant?	<input type="checkbox"/> Y <input type="checkbox"/> N
F) Who has accumulated claims in excess of \$25,000 in the past 12 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
G) Who has a history of requiring frequent medical treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N
H) Who has an autistic or otherwise psychiatrically disabled dependent?	<input type="checkbox"/> Y <input type="checkbox"/> N

QUESTION 3:

Are any medical benefits available to employees self funded by the Employer? (Ex: Behavioral Health, etc.)	<input type="checkbox"/> Y <input type="checkbox"/> N
If yes, A) Provide a Summary Plan Description document.	
B) Are these benefits available to all employees?	<input type="checkbox"/> Y <input type="checkbox"/> N
If no, explain why and detail the number of employees covered by these benefits.	

IF YOU ANSWERED "YES" TO ANY QUESTIONS ABOVE, PLEASE PROVIDE DETAILS BELOW:

Employee or Dependant	Gender	Age	Nature of Illness or Injury	Dates of Treatment	Claim Dollars Spent	Current Health Status	Current Enrollment
<input type="checkbox"/> E <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			/ /			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
<input type="checkbox"/> E <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			/ /			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
<input type="checkbox"/> E <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			/ /			<input type="checkbox"/> HMO <input type="checkbox"/> PPO
<input type="checkbox"/> E <input type="checkbox"/> D	<input type="checkbox"/> M <input type="checkbox"/> F			/ /			<input type="checkbox"/> HMO <input type="checkbox"/> PPO

By my signature, I certify to the best of my knowledge that the answers to the above questions are complete and correct. I understand that final rates and acceptance of the group are based in part on this information.

Agent Signature _____ Date _____