



## GROUP RISK QUESTIONNAIRE (For groups of 26 employees or more)

<b>Name of Business:</b>		<b>Renewal Date:</b>		
<b>Business Phone #:</b>		<b>Fax #:</b>		
<b>Type of Business:</b>		<b>Years in Business:</b>		
<b>CURRENT/PREVIOUS COVERAGE</b>				
<b>Current Carrier Name:</b>		<b>How Long:</b>		
<b>Benefits with Current Carrier:</b> <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity				
<b>Deductibles:</b>		<b>Coinsurance:</b>		
<b>Plan Type</b>	<b>Current Carrier Rates</b>	<b>Renewal Rates</b>		
<b>Employee</b>				
<b>Empl. &amp; Spouse</b>				
<b>Empl. &amp; Child</b>				
<b>Family</b>				
If this is replacement of prior coverage, please furnish a copy of your last billing statement with the employer form.				
<b>ELIGIBILITY</b>				
<b>Total # of Employees:</b>		<b>Total # of Eligible Employees:</b>		
<b>Total # of Eligible Employees Applying for Coverage:</b>				
<b>HEALTH QUESTIONS</b>				
Answer the following questions to the best of your knowledge for the persons to be insured (proprietors, partners, employees, spouses, and dependent children). <b>Give details for the persons answering "yes" on the back of this form.</b>				
			<b>Yes</b>	<b>No</b>
1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past twelve months?				
2. Is anyone likely to have a continuing claim from an existing mental or physical disorder?				
3. Has anyone been advised to have surgery in the last six months or anticipate hospitalization for any other reason?				
4. Are there any spouses or dependents that are incapacitated or confined in a hospital or treatment facility?				
5. Are there any employees who are not actively at work performing duties full time due to illness or injury?				
<b>The Prospective Applicant certifies that the above information is complete and true to the best of his/her knowledge.            Final rates subject to change if information does not adequately represent Group's actual medical history.</b>				
<b>Officer of Applicant &amp; Title:</b>			<b>Date:</b>	
<b>Agent's/Account Executive Signature:</b>			<b>Date:</b>	
<b>NOTE: A copy of this form will be returned to the employer if coverage is issued</b>				

<b>Medical Conditions:</b>
<b>Medical Conditions:</b>
<b>Medical Conditions:</b>
<b>Medical Conditions:</b>
<b>Medical Conditions:</b>