



## Group Health Questionnaire (page 1 of 5)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. Advantage Health Plans Trust will not accept the questionnaire if incomplete. Use additional paper if necessary.

Today's Date \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
<b>Company Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>County</b>		<b>Benefits Contact &amp; Phone #</b>			
<b>Total Number of employees on payroll:</b>	<b>Total Full Time:</b> <b>Total Part Time:</b>		<b>Total Number of employees currently enrolled in health care plan:</b>		
<b>Are any health plan enrollees NOT paid employees (other than spouses or children)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No ***If yes, please provide names and details:					
<b>Current Health Carrier:</b>			<b>Health Carrier Renewal Date:</b> /   /		
<b>Is your current Plan Self-Funded?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know   ***If yes, please provide claims.					
<b>Are you currently with a PEO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of PEO:			<b>Any ineligible class of employees</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which class:		
<b>Please provide a complete description of your business operation:</b>				<b>SIC Code:</b>	
<b>Number of Locations:</b> _____		<b>Please identify all states of operation:</b> _____			

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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.)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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II. RATE HISTORY <span style="float: right;">(if more than 3 plans, include the 3 most popularly-elected plans)</span>				
Plan 1 Name: _____	# Enrolled: _____	Renewal Rates (eff. ___/___/___)	Most recent 12 months	13-24 months prior
<b>Premium Rates</b>				
Employee Only	#	\$	\$	\$
Employee + Spouse	#	\$	\$	\$
Employee + Child(ren)	#	\$	\$	\$
Employee + Family	#	\$	\$	\$

Plan 2 Name: _____	# Enrolled: _____	Renewal Rates (eff. ___/___/___)	Most recent 12 months	13-24 months prior
<b>Premium Rates</b>				
Employee Only	#	\$	\$	\$
Employee + Spouse	#	\$	\$	\$
Employee + Child(ren)	#	\$	\$	\$
Employee + Family	#	\$	\$	\$

Plan 3 Name: _____	# Enrolled: _____	Renewal Rates (eff. ___/___/___)	Most recent 12 months	13-24 months prior
<b>Premium Rates</b>				
Employee Only	#	\$	\$	\$
Employee + Spouse	#	\$	\$	\$
Employee + Child(ren)	#	\$	\$	\$
Employee + Family	#	\$	\$	\$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION <span style="float: right;">(Individual, in-network only)</span>			
Current Plan Names:	1:	2:	3:
<b>Current Plan Types:</b>	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
<b>Annual Deductible</b>			
<b>Co-Insurance (as %)</b>			
<b>Out-of-Pocket Max</b> (excluding deductible)			
<b>Office Visit Copay</b>			
<b>Prescription Drug Copay</b> generic / brand formulary / brand non-formulary	/ /	/ /	/ /

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child	Family
<b>Company Contribution Levels (by \$ or %)</b>				

**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.**

<p><b>GENERAL ILLNESS QUESTIONS:</b></p> <p>a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?</p> <p>b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?</p> <p>c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?</p> <p><b><i>(If yes to any or all, please provide details in the table below.)</i></b></p>	<p>To the Best of My Knowledge (any or all):</p> <p><input type="checkbox"/> YES    <input type="checkbox"/> NO</p>
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<p><b>SPECIFIC ILLNESS QUESTION:</b></p> <p>Is anyone currently being treated or been advised to seek treatment for any of the following?</p> <p><b><u>Please check all that apply:</u></b></p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> AIDS or testing HIV Positive</td> <td><input type="checkbox"/> kidney disorder</td> <td><input type="checkbox"/> stroke</td> </tr> <tr> <td><input type="checkbox"/> arthritis</td> <td><input type="checkbox"/> liver disease</td> <td><input type="checkbox"/> substance dependency</td> </tr> <tr> <td><input type="checkbox"/> back disorder</td> <td><input type="checkbox"/> mental illness</td> <td><input type="checkbox"/> transplants</td> </tr> <tr> <td><input type="checkbox"/> cancer</td> <td><input type="checkbox"/> muscular disorder</td> <td><input type="checkbox"/> tumor</td> </tr> <tr> <td><input type="checkbox"/> diabetes</td> <td><input type="checkbox"/> nervous system disorders</td> <td></td> </tr> <tr> <td><input type="checkbox"/> heart disease</td> <td><input type="checkbox"/> respiratory disease</td> <td><input type="checkbox"/> other serious conditions</td> </tr> </table> <p><b><i>(If any boxes are checked, please provide details in the table below.)</i></b></p>	<input type="checkbox"/> AIDS or testing HIV Positive	<input type="checkbox"/> kidney disorder	<input type="checkbox"/> stroke	<input type="checkbox"/> arthritis	<input type="checkbox"/> liver disease	<input type="checkbox"/> substance dependency	<input type="checkbox"/> back disorder	<input type="checkbox"/> mental illness	<input type="checkbox"/> transplants	<input type="checkbox"/> cancer	<input type="checkbox"/> muscular disorder	<input type="checkbox"/> tumor	<input type="checkbox"/> diabetes	<input type="checkbox"/> nervous system disorders		<input type="checkbox"/> heart disease	<input type="checkbox"/> respiratory disease	<input type="checkbox"/> other serious conditions
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Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

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

<b>IS ANYONE CURRENTLY PREGNANT?</b> If yes, please provide due date and note below if <b>normal, high risk, multiple birth, or preterm labor</b> with this pregnancy.  <i>This includes employees, dependents or COBRA participants.</i>		To the Best of My Knowledge:  <input type="checkbox"/> YES <input type="checkbox"/> NO
Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

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 Advantage Health Plans Trust (AHPT) 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, AHPT may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, AHPT service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that Advantage Health Plans Trust also may adjust my contributions to properly reflect the underwriting risk present at the time of the original misrepresentation.

Advantage Health Plans Trust 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.

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

<b>Authorized Signature</b>	<b>Title</b>	<b>Date</b>
<b>Print Name</b>	<b>Print Name of Company</b>	
<b>Broker / Sales Signature</b>	<b>Broker / Sales Print Name</b>	<b>Date</b>