ADVANTAGE HEALTH PLANS TRUST

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.

Date _____ Proposed Effective Date: 1/1/13

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
Company Name					
Street Address					
City		**State**		**Zip**	
County		**Benefits Contact & Phone #**			
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: _____**			

A. List any <u>current</u> <u>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

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 %)				

- **Attach a copy of your benefit summary for each plan and year listed above.**
- **Include carrier claims report if available.**

Next, please answer the following questions on behalf of your company <u>to the best of your knowledge</u>. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

GENERAL ILLNESS QUESTIONS:	To the Best of My Knowledge (any or all):
a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability? c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? ***(If yes to any or all, please provide details in the table below.)***	❑ YES ❑ NO

SPECIFIC ILLNESS QUESTION:

Is anyone currently being treated or been advised to seek treatment for any of the following?

<u>Please check all that apply</u>:

❑ AIDS or testing HIV Positive	❑ kidney disorder	❑ stroke
❑ arthritis	❑ liver disease	❑ substance dependency
❑ back disorder	❑ mental illness	❑ transplants
❑ cancer	❑ muscular disorder	❑ tumor
❑ diabetes	❑ nervous system disorders	
❑ heart disease	❑ respiratory disease	❑ other serious conditions

(If any boxes are checked, please provide details in the table below.)

Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

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Known Medical Conditions <u>to the best of your knowledge</u> (continued):

IS ANYONE CURRENTLY PREGNANT? If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy. *This includes employees, dependents or COBRA participants.*	To the Best of My Knowledge: ❑ YES ❑ 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 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, the insurance carrier may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, Advantage Health Plans Trust 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 insurance premiums 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. Prospective employees in Michigan should not provide information regarding height or weight.

Advantage Health Plans Trust Program Notice of Privacy Practices provides more detailed information about how Advantage Health Plans Trust Program 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. Advantage Health Plans Trust Program and my health plan are not required by law to grant my request. However, if my request is granted, Advantage Health Plans Trust Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent Advantage Health Plans Trust Program 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 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.

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