

Group Risk Questionnaire

Company Name: _____

Address : _____

1. How long has your company been in business? _____

2. How many carriers have you had in the last five years? _____

List insurance companies or HMOs with which you had group plans in the last five years.

COMPANY NAME	PRODUCT /PPO /HMO	EFFECTIVE DATE OF PLAN

3. What are your current and renewal rates?

Current Rates: Employee: _____ Employee + Dependent: _____ Family _____ Effective Date: _____

Renewal Rates: Employee: _____ Employee + Dependent: _____ Family _____ Effective Date: _____

4. To the best of your knowledge are any employees or dependents (including COBRA eligibles) receiving treatment for a mental or physical disorder?

Yes No If "Yes", please explain _____

5. Are there any employees who are not actively at work due to illness or injury?

Yes No If "Yes", identify and give details: _____

6. Do you know of any employees or their dependents (including COBRA eligibles) who have any significant pre-existing conditions (including pregnancies) which could be expected to lead to surgery or hospitalization?

Yes No If "Yes", please explain: _____

7. Do you know of any employee's or dependents claims (including COBRA eligibles) exceeding \$5,000 in the last twelve (12) months?

Yes No If "Yes", please explain: _____

Small Employers: This information is used exclusively for coordinating continuation of care and impacts neither pricing decisions nor acceptance.

Large Employers: I realize that my group's coverage will not be made effective until the information given here is evaluated by HMO Colorado or Anthem Blue Cross and Blue Shield. I further certify that the information given is accurate and complete. _

OWNER/OFFICER/GROUP ADMINISTRATOR SIGNATURE _____ TITLE _____ DATE _____