Employee Benefits Group Universal Large Group Medical Questionnaire

Lightsource HR

Section 1: Group Information

Group's/Company's Legal Name:			**Requested Effective Date:**	
Street Address:			**Tax ID Number (FEIN):**	
City:	**State**	**Zip Code**	**Names of Owners/Partners (If Applicable):**	**Internet Access?** ◯ Yes ◯ No
Contact Person:		**Email Address:**		**# of Years In Business**
Billing Address (if different):		**Contact Phone:**		**Fax:**
Multi-Location Group/Company? ◯ Yes ◯ No	**# of Locations**	**Address(es) (or list on additional sheet of paper)**		
Organization Type: ◯ Partnership ◯ C-Corp ◯ S-Corp ◯ LLC/LLP ◯ Sole Proprietor ◯ Other_____		**Nature of Business:**		**Industry Code (SIC or NAICS):**
New Hire Waiting Period	◯ 1st of Policy Month following Date of Hire ◯ 1st of Policy Month following___ ◯ Months ◯ Days of employment ◯ Date of Hire (No Waiting Period) ◯_____ ◯ Months ◯ Days of employment following Date of Hire		**Waiting Period Waived for Initial Enrollees?** ◯ Yes ◯ No	**Medical Benefit Plan Option:** ◯ Calendar Year ◯ Policy/Plan Year
Total Number of Employees_____	**Total Number of Eligible Employees**_____	**Total Number of Ineligible Employees**_____	**Total Number of Covered Employees**_____	**# of Hours Worked to be eligible**_____
Number of Persons currently on COBRA/Continuation And/or Short/Long Term Disability (Employees/Dependents):_____		**Number of Employees Terminated in last 12 Months?**_____	**Classes Excluded:** ☐ None ☐ Union ☐ Hourly ☐ Non-Management ☐ Salary	
Do You Have Worker's Comp Coverage? ◯ Yes ◯ No	**Name of Worker's Compensation Carrier?**		**Domestic Partner Coverage?** ◯ Yes ◯ No	
Names of Owners/Partners not covered by Worker's Compensation:				

Section 2: Plan Information

1. Is there a group plan currently in place? ◯ Yes ◯ No **If Yes, please detail your 5-Year carrier history below:**

Carrier Name:_____ **Effective Date:**_____
Carrier Name:_____ **Effective Date:**_____
Carrier Name:_____ **Effective Date:**_____
Carrier Name:_____ **Effective Date:**_____
Carrier Name:_____ **Effective Date:**_____

2. Reason for Current Bid Request? _____

3. Please identify the current carrier(s), plan type, current rates and last rate increase below:

Carrier Name	Plan Type (PPO, POS, HMO)	EE Rate (Current)	EE + SP Rate (Current)	EE + CH Rate (Current)	EE + FAM Rate (Current)	Last Rate Increase %
		$_____	$_____	$_____	$_____	_____%
		$_____	$_____	$_____	$_____	_____%
		$_____	$_____	$_____	$_____	_____%
		$_____	$_____	$_____	$_____	_____%
		$_____	$_____	$_____	$_____	_____%

4. Please identify the employer monthly contribution percentage below:

EE _____% **EE & Spouse** _____% **EE & Child** _____% **EE & Family** _____%

5. Are these employee contributions the same for *all* employees? ◯ Yes ◯ No
If no, please explain _____

6. What classes are eligible for employer coverage? ☐ Full-Time ☐ Part-Time ☐ Other (Explain)_____ If Part-Time are eligible, are employer contributions the same as Full-Time employees? ◯ Yes ◯ No If No, please provide employer contributions for part-time employees:			
EE _____%	EE & Spouse _____%	EE & Child _____%	EE & Family _____%

Section 3: Healthcare Reform / ERISA / Legal Information

Enter the Prior Calendar Year Average Total Number of Employees ☐ Note: Only applies to groups with less than 100 Eligible Employees	Under Health Care Reform law, the number of employees means the average number of employees employed by the company during the preceding calendar year. An employee is typically any person for which the company issues a W-2, regardless of full-time, part-time or seasonal status or whether or not they have medical coverage. To calculate the annual average, add all the monthly employee totals together, then divide by the number of months you were in business last year (usually 12 months). When calculating the average, consider all months of the previous calendar year regardless of whether you had coverage with us, had coverage with a previous carrier or were in business but did not offer coverage. Use the number of employees at the end of the month as the "monthly value" to calculate the year average. If you are a newly formed business, calculate your prior year average using only those months that you were in business. Use whole numbers only (no decimals, fractions or ranges).
◯ Yes ◯ No	Are there any other entities associated with this group that are eligible to file a combined tax return under Section 414 of the Internal Revenue Code? If yes, please give the legal names of all other corporations and the number of employees employed by each. Note: If you answered yes, this answer impacts your answers to the other questions regarding group size.
◯ Yes ◯ No	Subject to ERISA? If No, please indicate appropriate category: ☐ Church ☐ Federal Government ☐ Indian Tribe – Commercial Business ☐ Non-Federal Government (State, Local or Tribal Gov.) ☐ Foreign Government/Foreign Embassy ☐ Non-ERISA Other _____
◯ Yes ◯ No	In the past 36 months, has the Group/Company or any affiliated entity filed for protection or operated under federal/state bankruptcy laws? (Chapter 7 or 11)
◯ Yes ◯ No	In the past 36 months, has any creditor filed or threatened to file a petition requesting the Group/Company or any affiliated entity be placed voluntarily into bankruptcy?
◯ Yes ◯ No	Does your group sponsor a plan that covers employees of more than one employer? If you answered Yes, then indicate which of the following most closely describes your plan: ☐ Professional Employer Organization (PEO) ☐ Multiple Employer Welfare Arrangement (MEWA) ☐ Taft Hartley Union ☐ Governmental ☐ Church ☐ Employer Association
◯ Yes ◯ No	Is your group a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), or other such entity that is a co-employer with your client(s) or client-site employee(s)? If you answered Yes, then by signing this application you agree with the certification in this section. I hereby certify that my company is a PEO, ELC or other such entity and that only those employees that are the corporate employees of my company, and not my co-employees, are permitted to enroll in this group policy. If my group at any point after I sign this application determines that the group will provide coverage to the co-employees under the group's plan, I understand that the chosen carrier will not cover the co-employees under this group policy.
◯ Yes ◯ No	Do you currently utilize the services of a Professional Employer Organization (PEO) or Employee Leasing Company (ELC), Staff Leasing Company, HR Outsourcing Organization (HRO), or Administrative Services Organization (ASO)?

Do you continue medical coverage during a leave of absence (not including state continuation or COBRA coverage), and if so, for how long once an employee begins a leave of absence?

(Please refer to the applicable state and federal rules that may require benefits to be provided for a specific length of time while an employee is on leave.)

- ◯ **Last Day worked (following the last day worked for the minimum hours required to be eligible)**
- ◯ **3 Months (following the last day worked for the minimum hours required to be eligible)**
- ◯ **6 Months (following the last day worked for the minimum hours required to be eligible)**
- ◯ **No, we do not offer medical coverage during a leave of absence**

Employee Benefits Group Universal Large Group Medical Questionnaire

COUNTRYWIDE HR

Section 4: Medical Profile / Disclosures

If you are applying for medical coverage, please answer the following questions to the best of your knowledge by referencing available employee records and other personnel documents for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses, and dependent children) to the extent permitted by applicable law. The Carriers are only seeking to collect information about the current health status of those employees and their dependents who are applying for coverage. In answering these questions, do not include any genetic information about your employees or their dependents, including requests for genetic services, genetic diseases for which they may be at risk or family medical history information.

Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

Yes No 1. Within the past 3 years, has any employee or dependent filed a claim for short-term disability, long term disability, social security disability income, workers' compensation, Medicare, or Medicaid benefits or any other type of disability benefits on any policy?

Yes No 2. During the past 3 years, has any employee or dependent had life, disability or health insurance declined, postponed, changed, cancelled or withdrawn?

Yes No 3. Except for a maternity or paternity leave, within the past 3 years, has any employee applied for a family or medical leave of more than 2 weeks due to injury, disability or illness of the employee or dependent?

Yes No 4. Within the past 3 years, has any employee been absent from work for more than 2 consecutive weeks due to injury, disability or illness?

Yes No 5. Except for a mental health admission, during the past 3 years, has any employee or dependent had a hospital stay lasting more than 5 days or is any employee or dependent contemplating treatment that would require hospitalization for more than 5 days?

Yes No 6. Is any employee or dependent currently hospitalized?

Yes No 7. Within the last 12 months has any employee or their eligible dependent been hospitalized or had any surgical consultation advice or treatment for any condition?

Yes No 8. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

Yes No 9. Is any employee presently not performing his or her duties on a full-time basis due to an illness or injury?

Yes No 10. Have any claims greater than $25,000 been paid in the last 12 months?

Yes No 11. Within the past 12 months, has any employee or dependent had a serious continuing claim (i.e., chronic or ongoing condition likely to cost $10,000 or more per year for treatment) due to a mental or physical disorder?

Yes No 12. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period:

- confined at home, in a hospital, or in a treatment facility — **Yes No**
- who incurred more than $25,000 of medical expenses in the past 12 months — **Yes No**
- who has been advised within the last 90 days to have surgery or be hospitalized — **Yes No**

(Continued on Next Page)

Section 4: Medical Profile / Disclosures, Continued

13. To the best of your knowledge, is there any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period who received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist or other licensed practitioner within the past 24 months for any of the following: (Please check any that apply)

☐	AIDS / Immune Disorders	☐	Cardiovascular / Circulatory	☐	Infertility	☐	Multiple Sclerosis
☐	Alcohol Abuse	☐	Diabetes	☐	Intestines	☐	Neurological
☐	Arthritis	☐	Drug / Substance Abuse	☐	Kidney Disease / Failure	☐	Pancreas
☐	Back / Neck	☐	Epilepsy / Seizure	☐	Liver	☐	Skin
☐	Blood	☐	Ears / Eyes	☐	Lungs	☐	Stomach
☐	Bone / Joint	☐	Emphysema / Pulmonary	☐	Lupus	☐	Stroke / Paralysis
☐	Brain	☐	Heart Disease	☐	Mental / Nervous / Emotional	☐	Venereal
☐	Cancer / Tumor	☐	High Risk Pregnancy	☐	Migraines	☐	Other, Detail Below

◯ Yes ◯ No 14. Are any employees or dependents currently pregnant? If Yes, how many? _____

15. If you answered Yes to any of the questions above, or checked any of the boxes in question #14, please provide the following information for each individual with a likely serious continuing condition. Use an additional sheet if necessary.

Question Number	Check One EE	Check One DEP	Age	Date of Recovery	Date of Treatment / Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Current Treatment
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							
	☐	☐							

Employee Benefits Group Universal Large Group Medical Questionnaire

COUNTRYWIDE HR®

Section 5: Disclosure & Signature

This risk assessment is intended to help the carrier underwrite the group's request for group insurance. Additional information may be required on employees who are required to answer medical questions for any conditions not disclosed on this form. This information could potentially impact underwriting's final decision. Any person who knowingly, and with intent to defraud an insurer, files an application for insurance containing a false or deceptive statement may be guilty of a fraudulent insurance act. Fraud or misrepresentation may be grounds for non-renewal or termination under the terms of the group policy.

I hereby represent to the best of my knowledge the information, statements and answers recorded on this form are complete and accurate.

Employer Authorized Purchaser signature: _____

Printed Name:_____Title: _____

Date: _____

Agent Signature: _____Date: _____

Printed Name: _____Agent ID: _

Agency Name: _____Agency Tax ID: _____

Please Note: This Large Group Questionnaire has been created by aggregating the information requests and health questions from each of the specific carrier questionnaires from which you will be receiving quotes. As this questionnaire will only suffice for marketing purposes; should you choose to place your health plan with any of the quoted carriers, you will need to complete and sign the chosen carrier's preferred Large Group Questionnaire as it is part of the paperwork required for installation.