Group Health Questionnaire

This questionnaire must be filled out completely. Please be sure to indicate "none" if applicable. CountryWide HR will not accept the questionnaire if incomplete. Use additional paper if necessary.

Date: _________________________ Proposed Effective Date: _________________________

I. Company and Current Enrollment Information

Company Name: ____

Street Address: _______________________________________ City: _______________________ State: ______ ZIP Code: _________

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*, please name the 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: __________________________________

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A. List any current participants in COBRA/State Continuation (use additional paper if necessary):

☐ None

Name & DOB	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 & DOB	Date Eligible	Activating Event & Date

C. List any employees and/or dependent who are on the health plan that are disabled:

☐ None

Name & DOB	Disability	Qualifying Event

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II. Rate History

If more than 3 plans, include the 3 most popularly-elected plans.

Plan #1 Name: _____________________________ Renewal Rate Effective Date: __________

Premium Rates	# Enrolled	Renewal Rates	Most Recent 12 Mos.	13-24 Months Prior
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan #2 Name: _____________________________ Renewal Rate Effective Date: __________

Premium Rates	# Enrolled	Renewal Rates	Most Recent 12 Mos.	13-24 Months Prior
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan #3 Name: _____________________________ Renewal Rate Effective Date: __________

Premium Rates	# Enrolled	Renewal Rates	Most Recent 12 Mos.	13-24 Months Prior
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

Individual, in-network only.

	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.

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Next, please answer the following questions on behalf of the 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.

General Illness Questions:

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, or 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?

To the best of my knowledge, are any or all of these true? ☐ Yes ☐ No

Specific Illness Question:

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

Please check all that apply.

☐ AIDS or testing HIV Positive
☐ Arthritis
☐ Back disorder
☐ Cancer
☐ Diabetes
☐ Heart disease
☐ Kidney disorder
☐ Liver disease
☐ Mental illness
☐ Muscular disorder
☐ Nervous system disorders
☐ Respiratory disease
☐ Stroke
☐ Substance dependency
☐ Transplants
☐ Tumor
☐ 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

Is anyone currently pregnant? ☐ Yes ☐ No

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.

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 odes not bind coverage. I will notify CWHR 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, CWHR service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that CWHR also may adjust my insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation.

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CWHR 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.

CWHR Program Notice of Privacy Practices provides more detailed information about how CWHR 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. CHWR Program and my health plan are not required by law to grant my request. However, if my request is granted, CHWR Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent CHWR 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 with 90 days of date signed. I will notify CWHR of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage. I understand that CWHR reserves the right to re-underwrite based on a change in the Census or Demographics.

Signature: ____ **Title:** __________________________ **Date:** _______________

Print Name: ____ **Print Name of Company:** _______________________________

Broker/Sales Signature: ____ **Date:** _______________

Broker/Sales Print Name: _______________________________________