EMPLOYER QUESTIONNAIRE

Name of Employer	Business Telephone (*include area code)*	
Employer's Street Address	City, State, and Zip Code	
Type of Business	Years in Business	Federal Tax ID No.

1. ***Describe all medical plans offered during the last three years:***

Carrier name	Plan Name/Description	Period in effect

2. ***Please furnish a copy of your last billing statement for medical coverage, along with this form.***

3. ***Please provide the following information regarding eligibility and participation:***

Total number of full-time, part-time and seasonal employees _____ Hours per week to be full-time _____ hours

Total number of **eligible** full-time employees _____ Total number of employees covered in current medical plan _____

Are retirees eligible? ☐***Yes*** ☐***No*** ***If so, identify on census and provide eligibility requirements.***
Any current Cobra members? ☐***Yes*** ☐***No*** ***If so, identify on census,***

4. ***Answer the following questions to the best of your knowledge for the persons eligible for medical insurance (include proprietors, partners, employees, spouses, and dependent children). Please give details to questions answered "Yes" on a separate sheet of paper.***

A. Has anyone been treated for a serious illness, been hospitalized, or had surgery during the past 12 months? ☐ Yes ☐ No

B. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No

C. Has anyone been advised during the last six months to have surgery or does anyone anticipate being hospitalized for any other reason? ☐ Yes ☐ No

D. Are there any employees who, because of illness or injury, are not actively at work performing their normal duties on a full-time basis? ☐ Yes ☐ No

E. Are there any spouses or dependents who, because of illness or injury, are not actively at work or otherwise performing their normal duties on a full-time basis? ☐ Yes ☐ No

5. ***Please list below any claims during the past 18 months that exceeded $10,000. (If detailed claim information is not provided to you, please list serious claims that may have exceeded this amount.) Please provide diagnosis and current status.***

Patient	Amount of claim	Approximate date	Diagnosis	Status
1.				
2.				
3.				

6. ***Please provide current premium rates (and, if known, renewal premium rates).***

	Current Rates	Renewal Rates	Employer Contribution
Single	$	$	$ or %
Employee/Children	$	$	$ or %
Employee/Spouse	$	$	$ or %
Family	$	$	$ or %

The prospective applicant hereby certifies that the above information is complete and true to the best of his/her knowledge.

Employer	Date
Printed name and title	Signature

PLEASE COMPLETE ENTIRE DOCUMENT