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Employer Risk Evaluation Form

Name of Employer: Fed. Tax ID#: Date Completed:

Address: City: State: Zip:

Type of Business: Affiliate Companies: SIC Code:

Describe all medical plans offered during the last five years:

Carrier Name	Type of Coverage(PPO,HMO, Indemnity, deductibles/copays)	Period in effect

Please provide the following information regarding eligibility and participation:

Total number of full-time employees: Hours per week to be full-time:

Total number of eligible full-time employees:

Total number of employees currently enrolled in the medical plan:

Employer contribution level: Single coverage: Dependent coverage:

Are there any members participating in the medical plan who have incurred medical expenses in excess of $10,000 in the last month?

Name	Employee, Spouse or dependent	Diagnosis	Claim Amount	Status

COBRA: Is anyone currently eligible or enrolled in COBRA? If yes, please list below:

Name	Date of Qualifying Event	Expiration Date	Qualifying Event

Retirees: Is anyone currently enrolled in the plan as a retiree? If yes, please list below:

Name	Age at retirement	Date of retirement	% of Employer Contribution

Have any employees been absent from work for 5 or more consecutive days due to illness or injury in the last 12 months?

Name	Period of time absent	Reason

Please provide the rate history for your group and renewal rates, if known:

	Prior Year Rates	Current Rates	Renewal Rates
Single			
Employee and Spouse			
Employee and Child			
Family			

1. Please answer the following questions to the best of your knowledge(including spouses and/or dependents). Please provide details in the box below.

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

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

C. 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

Are there any spouses or dependents who, because of illness or injury, are not actively at work or not performing age appropriate activities of daily living? ◯ Yes ◯ No

2. Complete the following for any known medical conditions in your group:

- ☐ AIDS, HIV+
- ☐ Alzheimers
- ☐ Aneurysim
  - Type: _____
- ☐ Rheumatoid Arthritis
- ☐ Hemophilia
- ☐ Kidney Dialysis/Renal Failure
- ☐ Liver (Cirrhosis)
- ☐ Liver (Hepatitis non-alcoholic)
- ☐ Lupus/Connective Tissue Disorder

- [ ] Back/Spine Injuries
  - Type:
- [ ] Cancer Present (within 12 months)
  - Type:
  - [ ] Recovered 1-2 years
    - Type:
  - [ ] Recovered 3-5 years
    - Type:
  - [ ] Recovered 6-10 years
    - Type:
  - [ ] Recovered 10+ years
    - Type:
- [ ] Cerebral Palsy
- [ ] Circulatory: Coronary Artery Disease(last 5 years)
- [ ] Circulatory: Heart Attack
  - [ ] Operated [ ] Unoperated
- [ ] Chronic Obstructive Pulmonary Disease (COPD)
- [ ] Crohn's Disease
- [ ] Cystic Fibrosis
- [ ] Diabetes
  - [ ] Diet Controlled
  - [ ] Insulin-Adult onset
  - [ ] Insulin-Child onset
  - [ ] Oral Medications
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Lyme's/Parasitic Disease
- [ ] Lymphoma/Leukemia
- [ ] Mental Health Disorder
  - Type:
  - [ ] Schizophrenic Disorders
  - [ ] Anxiety Disorders
  - [ ] Depressive Disorder
- [ ] Multiple Sclerosis
- [ ] Muscular Dystrophy
- [ ] Pancreatitis
- [ ] Paralysis
- [ ] Pregnancy
  - Due Date:
- [ ] Spinal Bifida
- [ ] Stroke (within last 5 years)
- [ ] Substance Abuse (within 5 years)
- [ ] Transplant
  - Type and Date
- [ ] Ulcerative Colitis
- [ ] Other
  - Type:

3. Is there any additional information that you think will assist in assessing the medical condition(s) present in your group? If so, please provide in the space below.

The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employer Representative: Date:

Printed Name and Title: Signature:

Sales Representative: Broker Signature:

Submit by Email