

# Employer Risk Questionnaire



Employer's legal name \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

Complete address \_\_\_\_\_

Exact nature of business \_\_\_\_\_ Number of years in business \_\_\_\_\_

Name of correspondent \_\_\_\_\_ Title \_\_\_\_\_

Employer contribution \_\_\_\_% Single \_\_\_\_% Dependent Contribution Based On \_\_\_\_\_

Total full-time employees \_\_\_\_\_ Total employees participating \_\_\_\_\_  
 Number of COBRA enrollees \_\_\_\_\_ Number of Carriers Last 5 Years \_\_\_\_\_

The following questions must be answered thoroughly and accurately and to the best of your knowledge and belief. Any ambiguity may delay approval. These questions apply to all active employees and their dependents as well as all COBRA participants and their dependents. Please provide details to all "YES" responses in the spaces provided below. Additional sheets may be used if needed.

1. In the past twelve months, has any employee or dependent incurred medical claims in excess of \$10,000?  Yes  No
2. As of this date, are there any employees or dependents to be covered that are disabled, unable to perform normal duties or not working full time at 25 hours per week?  Yes  No
3. Have any employees been absent for seven or more days in the past twelve months due to illness or any dependents hospitalized for seven or more days in the past twelve months?  Yes  No
4. Are you currently aware of any chronic medical conditions afflicting any employee or dependent (cancer, diabetes, heart, hypertension, kidney, or been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection, etc.) ?  Yes  No
5. Are any employees or dependents currently pregnant?  Yes  No  
 If yes, how many and what is the expected delivery date? \_\_\_\_\_
6. Are there any employees who are currently on COBRA?  Yes  No  
 If yes, please provide the reason for election of COBRA (i.e. between jobs, loss of dependent or student status or disability), date of onset and date of termination. \_\_\_\_\_

Question#	Date	Diagnosis	Dollar Amt. of Claim	Current Health Status

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_