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 in the 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 that your employees or their dependents might have? This would include any cancers, diabetes, heart problems, kidney problems, lung problems, blood diseases, dialysis, past or future transplants, HIV, AIDS, complicated pregnancies, or children with birth defects? ☐ 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 Amount of Claim	Current Health Status

Authorized Signature: _____ Date: _____