

Business Underwriters Associates Employer Questionnaire

Name of Employer		Business Phone	Tax ID	Years In Business
Address	City	County	State	Zip
Type of Business		Affiliate Companies	Email Address	

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

Carrier Name	Type of Coverage (PPO, HMO, Indemnity, deductibles/copays)	Period in Effect
1		
2		
3		

2. Please furnish a copy of your last billing statement and current benefit summary, along with this form.

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

Total number of full time employees: _____ Hours per week to be full time: _____ hours
 (If less than 50 employees use 25 hours a week)

Total number of part time employees: _____

Total number of employees currently enrolled in the medical plan: _____

4. Employer Contribution level: Single Coverage: _____ Dependent Coverage: _____

5. Are there any members participating in the medical plan who have incurred medical expenses in excess of \$10,000 in the last 18 months?

Name	Employee, Spouse or Dep	Diagnosis	Claim Amount	Status
1				
2				
3				

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

Name	Date of Qualifying Event	Expiration Date	Qualifying Event
1			
2			
3			
4			
5			

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

Name	Age at Retirement	Date of Retirement	% of Employer Contribution
1			
2			
3			

8. 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
1		
2		
3		

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

	Prior Year Rates	Current Rates	Renewal Rates
Employee			
Employee & Spouse			
Employee & Child			
Family			

Business Underwriters Associates Employer Questionnaire

Medical Information

Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance (including dependents). Please provide details on a separate sheet of paper.

1	<p>A Has any been treated for serious illness, been hospitalized or had surgery during the past 12 months?</p> <p>B Is any expected to have a continuing claim for an existing mental or physical disorder?</p> <p>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?</p> <p>D Are there any spouses or dependents who, because of illness or injury, are not either actively at work or not performing age appropriate activities of daily living?</p>	<table border="1" style="border-collapse: collapse; width: 100%;"> <tr><td style="width: 50%; height: 25px;"></td><td style="width: 50%; text-align: center;">YES</td><td style="width: 5%;"></td><td style="width: 50%; text-align: center;">NO</td></tr> <tr><td style="height: 25px;"></td><td style="text-align: center;">YES</td><td></td><td style="text-align: center;">NO</td></tr> <tr><td style="height: 25px;"></td><td style="text-align: center;">YES</td><td></td><td style="text-align: center;">NO</td></tr> <tr><td style="height: 25px;"></td><td style="text-align: center;">YES</td><td></td><td style="text-align: center;">NO</td></tr> </table>		YES		NO		YES		NO		YES		NO		YES		NO
	YES		NO															
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	YES		NO															

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

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3 Is there any additional information that you think will assist us in assessing the medical conditions present in your group? If so, please provide in the space below:

The prospective client 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 a false or deceptive statement is guilty of insurance fraud. This is not an application for insurance coverage.

Employer Representative	Date
Title	Signature