

Group Size 51-99

Name of employer	Business telephone no. (include area code)	
Type of business	Years in business	Federal Tax ID no.

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

Carrier name	Type of coverage	Period in effect
1.		
2.		
3.		

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 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 _____

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
Single	\$	\$
Employee/Children	\$	\$
Employee/Spouse	\$	\$
Family	\$	\$

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
Sales representative	Broker