

EMPLOYER RISK APPRAISAL

1. This questionnaire is designed to provide information specific to your group.
2. The information will be used in evaluating the risk characteristics of your group to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.
3. Please answer all questions to the best of your knowledge.
4. Groups of 1-24, please complete sections 1, 2 and 3 and sign the back of the form. Groups of 25+, complete all sections and sign the back.

TAX IDENTIFICATION NUMBER
BROKER NAME

PLEASE PRINT. DO NOT WRITE IN SHADED AREAS. COMPLETE BOTH SIDES, IN INK.

1. BUSINESS PROFILE

BUSINESS NAME		TELEPHONE NUMBER	
BUSINESS ADDRESS (MUST BE A PHYSICAL STREET ADDRESS)		CITY	COUNTY
		STATE	ZIP
		COUNTY CODE	
BUSINESS HEADQUARTERS (CITY, COUNTY, STATE)		OTHER BUSINESS LOCATIONS (CITY, COUNTY, STATE)	
		CONTACT NAME AND POSITION	
TYPE OF BUSINESS	NAICS CODE	YEARS OF OPERATION	Small Employer as defined by North Carolina Statutes (NCGS 58-50-110[22])? <input type="checkbox"/> Yes <input type="checkbox"/> No
What type of ownership is this business entity? <input type="checkbox"/> Proprietorship <input type="checkbox"/> Self-Employed <input type="checkbox"/> Partnership <input type="checkbox"/> Statutory 1099 Employee <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Church/Nonprofit <input type="checkbox"/> Corporation <input type="checkbox"/> Other: _____			
Ever filed for bankruptcy or in the process of filing? <input type="checkbox"/> Yes <input type="checkbox"/> No		INDICATE CHAPTER FILED	Has the Bankruptcy Court approved reorganization? <input type="checkbox"/> Yes <input type="checkbox"/> No
		Please provide documentation of approval to reorganize.	

2. GROUP ELIGIBILITY PROFILE

This information will be compared to actual enrollment, if your group does enroll. A difference between the enrollment information in the "Group Eligibility Profile" shown here and actual enrollment may invalidate the proposed rates.

- a. Total number of employees, including full-time and part-time _____
- b. Total number of employees eligible for health coverage, including employees who will be eligible upon completion of their probationary period _____
The group certifies that all individuals enrolling for coverage meet the following definition of eligible employee:
 An eligible employee is an individual working 30 hours or more per week on a full time basis with the employer reporting the FICA withheld by W2 Form on an annual basis. In addition, for groups defined as Small Employer groups, persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible. An individual who is a "statutory employee" as that term is defined under Internal Revenue Code Section 3121 (d) (3) and works on a full time basis for the group may be considered eligible for coverage. Documentation of "statutory employee" status is required. When determining employee eligibility for groups of 51 or more, an individual proprietor, owner, or operator shall be defined as an "employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees.
- c. Total number of employees applying for health coverage _____
- d. Total number of employees applying for dental coverage _____
- e. Total number of employees who are not applying that have other group coverage _____
- f. Total number of former employees or their dependents continuing coverage through COBRA or state continuation provisions _____

Please provide the following information:

NAME OF PARTICIPANT	EMP. OR DEP.	AGE	NATURE OF QUALIFYING EVENT	DATE OF QUALIFYING EVENT	MONTHS REMAINING
_____	<input type="checkbox"/> EMP. <input type="checkbox"/> DEP.	_____	_____	_____	_____
_____	<input type="checkbox"/> EMP. <input type="checkbox"/> DEP.	_____	_____	_____	_____
_____	<input type="checkbox"/> EMP. <input type="checkbox"/> DEP.	_____	_____	_____	_____

- g. Will all employees and their dependents enrolling for health coverage be required to enroll for dental coverage? Yes No Not applying for Dental Coverage
- h. Are all eligible employees covered by workers' compensation? Yes No
- i. Please indicate the probationary period requested for new employees..... 0 30 60 90
- j. Is this entity a Professional Employer Organization (PEO)? Yes No
- k. Is your business currently enrolled in a Professional Employer Organization with leased employees? Yes No
- l. For groups of 51 or more eligible employees: Will employees and their dependents be subject to a waiting period for pre-existing conditions (health coverage only)? Yes No

If yes, what is the pre-existing condition option you are selecting? (Please check one option below)

(First Option Applies to all Small Employer Groups)

- Pre-existing waiting period applies to all enrollees (timely and late) (Applies to All Small Employer Groups)
- Pre-existing waiting period is waived for group's original effective date enrollees; Pre-existing waiting period applies to subsequent enrollees (timely and late)
- Pre-existing waiting period waived for group's original effective date enrollees and subsequent timely employees; Pre-existing waiting period applies to late enrollees

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m. Do any applying employees reside outside North Carolina? Yes No

Please provide the following information:

STATE OF RESIDENCE	NUMBER APPLYING	STATE OF RESIDENCE	NUMBER APPLYING
_____	_____	_____	_____
_____	_____	_____	_____

n. Are there any other employer sponsored health plans which will be in force concurrently? Yes No

Please provide the following information:

CARRIER	TYPE OF BENEFITS	NUMBER ENROLLED	% EMPLOYER CONTRIBUTION
_____	_____	_____	_____

3. CURRENT CARRIER PROFILE

a. Please provide a five year history of group health insurance carriers, including your current carrier:

CARRIER NAME(S)	START DATE	PERIOD(S) INSURED	END DATE	REASON FOR TRANSFER
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

b. Please provide your current and renewal health rates, including any prescription drug riders:

CARRIER NAME(S)	NUMBER OF SUBSCRIBERS	CURRENT HEALTH RATES	RENEWAL HEALTH RATES
Employee Only	_____	_____	_____
Employee + 1	_____	_____	_____
Employee + 2 or more	_____	_____	_____
Employee and Child(ren)	_____	_____	_____
Employee and Spouse	_____	_____	_____
Employee and Family	_____	_____	_____

c. What is the employer's contribution to the cost of the health program? **(minimum contribution is 50%)**

Employee coverage _____% Dependent coverage _____%

d. What is the employer's contribution to the dental program?

Employee coverage _____% Dependent coverage _____%

e. Please attach a copy of these forms to complete the appraisal:

- Current health carrier's latest billing statement and a description of benefits.
- Current employee census, showing age or date of birth, split by business location.
- Current health and dental carrier's latest renewal letter.
- Dental carrier's billing statements – current and 12 months old.

4. HEALTH INFORMATION PROFILE

Please provide the answers to the following questions to the best of your knowledge as they pertain to all eligible employees and/or covered dependents. It is important that you include information pertaining to those members continuing through COBRA or state continuation programs.

a. Has any person to be covered had any of the following conditions?

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Tumors	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back disorders	<input type="checkbox"/>	<input type="checkbox"/>	Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Chronic lung disorders	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes or high blood sugar	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Nervous System disorder	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug dependency or abuse	<input type="checkbox"/>	<input type="checkbox"/>	Acquired Immunity Deficiency Syndrome or Human Immuno-deficiency Virus Infection	<input type="checkbox"/>	<input type="checkbox"/>
Mental Disorder/Depression	<input type="checkbox"/>	<input type="checkbox"/>						

b. Are any eligible employees or dependents currently pregnant? Yes No

c. Are any employees or dependents contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery? Yes No

For each item checked "Yes" above, please explain below (if more space is needed, attach a separate sheet):

DIAGNOSIS	TREATMENT AND MEDICATIONS	LAST DATE TREATED
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in the Employer Risk Appraisal is complete, including attachments, and accurate to the best of my knowledge. It is further understood that any misrepresentation or false statements will subject any issued Group Contract to immediate termination by Blue Cross and Blue Shield of North Carolina.

Owner or Authorized Executive Signature _____ Date _____

Print Name _____