

Humana Pre-Quote/Risk Assessment Form

Sales Person: _____

Sales Office: _____

Company Name: _____

Quote #: _____

Agent Name: _____

Is this the agent of record? YES NO

SIC Code: _____

How Long? _____

1) Does the group have a current healthcare carrier? YES NO

a) Carrier Name: _____

b) Renewal Date: _____

2) The number of different carriers your group has had in the last 5 years: _____

3) The number of employees currently eligible for group coverage under your plan: _____

4) If the size of your group has significantly changed during the past year please explain why: _____

5) The number of employees currently enrolled for coverage under your plan: _____

6) The percent of premium the employer will be contributing to the employee premium: _____

7) In accordance to YOUR company records, and to the best of your knowledge, answer the following questions:

a) Has any employee missed 10 consecutive days of work in the past 12 months due to illness or injury? YES NO

b) Is any employee NOT performing his or her duties on a full-time basis due to an illness or injury? YES NO

c) Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period:

* Currently confined at home, in a hospital, or any treatment facility? YES NO

* Had more than \$10,000 of medical expenses in the past 24 months? YES NO

* Been advised within the past 90 days to have surgery or be hospitalized? YES NO

d) Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period received treatment, had treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist, or other licensed practitioner within the past 24 months for any of the following: (If yes, check all that apply). YES NO

AIDS or an AIDS-related complex or other immune system disorder

Alcohol or drug abuse or dependence, or psychological disorder

Cancer or cancerous tumor

Heart or vascular disease, or stroke

Diabetes or any disease or disorder of the kidneys, liver or lungs

Systemic disease such as Lupus, Multiple Sclerosis, or Muscular Dystrophy

Organ transplant (other than corneal)

For any "YES" answers given to the above questions, please provide additional information below for each individual. If additional space is needed, please use a signed and dated addendum.

Question #	Member Type*	Age	Medical Diagnosis/Condition	Dates of Treatment	Medication Name/Dosage	Past/Current/Future Treatment

* Member Type E = Employee, C = COBRA, D = Dependent, R = Retiree

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8) Has YOUR company, at any time during the past 24 months, had medical coverage terminated or a renewal of medical coverage refused?
 YES NO If yes, please provide details: _____

9) Have any medical benefits now, or within the past 24 months been partial self-funded or self-funded by YOU in any manner other than health insurance premium payments?
 YES NO
 If YES, please provide details AND attach medical claims experience and monthly enrollment in the plan within 3 months of the proposed effective date (up to 24 months in arrears).

10) Are retirees under the age of 65 eligible for coverage under your plan? YES NO
 If YES, the number of retirees under the age of 65 for coverage under your plan is: _____

11) If medical coverage is requested, provide the current and renewal Medical insurance premium rates below AND attach a copy of your most recent premium bill. Please indicate the number of individuals covered in each tier in the renewal rates portion below.

Current Plan Design

HMO
 Office Visit Copay _____
 Network Name _____
 ER Copay _____
 Per Confinement Copay _____
 Rx Benefit _____

PPO/POS
 Office Visit Copay _____ Plan Design _____
 Network Name _____ ER Copay _____
 Rx Benefit _____
 Deductible (IN) \$ _____ (OUT) \$ _____
 COINS (IN) \$ _____ (OUT) \$ _____
 - or -
 OOP (IN) \$ _____ (OUT) \$ _____

of employees in each tier
 EE _____ EE+CH _____
 EE+SP _____ FAM _____

of employees in each tier
 EE _____ EE+CH _____
 EE+SP _____ FAM _____

CURRENT RATES (Please indicate if current and/or renewal rates include prescription drug coverage)

HMO
 Employee \$ Spouse \$
 Child(ren) \$ Family \$

PPO/POS
 Employee \$ Spouse \$
 Child(ren) \$ Family \$

RENEWAL RATE

HMO
 Employee \$ Spouse \$
 Child(ren) \$ Family \$

PPO/POS
 Employee \$ Spouse \$
 Child(ren) \$ Family \$

Under no circumstances should you cancel your present group insurance coverage without written notice of approval from Humana insurance.

This proposal is intended to help Humana insurance underwrite your firm's requests for group insurance. This form must be completed by an officer of your company who knows, or can obtain, the healthcare history of the company's employees and their dependents. The officer should complete this form on the basis of that information and to the best of that officer's knowledge. Additional information may be required on employees who are required to answer medical questions, for any conditions not disclosed on this form. This information could potentially impact underwriting's final decision.

Completed By: _____ Title: _____

Date: _____