



## Employer Risk Appraisal Questionnaire Groups 26+ Employees



This questionnaire is designed to provide information specific to your group and will be used by WellPath Select, Inc. (WP) and/or Coventry Health & Life Insurance Company (CHL) in evaluating the risk characteristics to more accurately establish rates, benefits and eligibility rules as part of your application for coverage.

<b>I. GENERAL INFORMATION</b>							
Company Name							
Company Address/City/State/Zip							
Phone Number				Requested Effective Date			
Nature of Business & SIC				Years in Operation			
Reason Out to Bid							
Please list any employer locations other than noted above.							
<b>II. GROUP ELIGIBILITY</b>							
Total Employees: _____ = Full-time: _____ + Part-Time: _____; COBRA _____ Retirees _____							
Total Eligible Employees: _____ = Currently Covered _____ + Waiving Coverage _____ + Declines _____							
Employer Contribution: Employee _____ % Dependents _____ %							
Waiting Period (circle): 0 30 60 90 days; <input type="checkbox"/> Date of Hire (Cannot exceed 90 days from hire date) <input type="checkbox"/> 1st month after Waiting Period							
<b>Please see your WP/CHL rate proposal for complete eligibility and quoting policies.</b>							
Please identify on census or attach a list of all:							
• COBRA: former employees and/or dependents covered or eligible to receive coverage under state or COBRA continuation. Please list employees' termination date and reason for eligibility.							
• Retirees: if eligible for coverage with WP/CHL.							
• Out of Area employees/members applying for coverage with WP/CHL.							
• Part Time: <30 hours per week are not eligible for coverage.							
Are all eligible employees covered by Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If no, please explain:							
If there are company locations other than noted above, please provide the following information:							
Zip: _____	State of Residence: _____	No. of Eligibles: _____	Zip: _____	State of Residence: _____	No. of Eligibles: _____		
_____	_____	_____	_____	_____	_____		
Will other employer sponsored health plans concurrently remain in force? <input type="checkbox"/> Y <input type="checkbox"/> N If yes, please provide the following:							
Carrier: _____	Type of Benefits: _____	Number Enrolled: _____	% Employer Contribution: _____				
_____	_____	_____	_____				
Are there any individuals that are not employees, dependents or retirees that are covered under your previous carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No							
These individuals may not be eligible for coverage. Please contact your WP/CHL account representative.							
<b>III. COVERAGE INFORMATION (List all health carriers in the last three years)</b>							
Carrier		Effective Date		Types of Coverage		Reason for Change	
RATES	Employee	EE/Spouse	EE/Child(ren)	Family	Plan Description*		
Current	\$ _____	\$ _____	\$ _____	\$ _____			
Renewal	\$ _____	\$ _____	\$ _____	\$ _____			

### III. Coverage Information Continued:

\*Please attach a current benefit booklet, previous benefits, and plan changes for the most recent 2-year period.

Previously covered by WellPath/Coventry?  Yes  No

If yes, please provide the time covered: \_\_\_\_\_ through \_\_\_\_\_.

### IV. HEALTH INFORMATION

Provide the answers to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs, and eligible retirees).

**A.** To your knowledge has any person (employee and/or employee's dependents, or COBRA individuals) to be covered had any of the following conditions? **(Please check Yes or No. If yes, please circle all conditions that apply.)**

- |  |                              |                             |                    |
|--|------------------------------|-----------------------------|--------------------|
| 1. Alcohol or substance abuse  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 2. Arthritis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 3. Asthma, emphysema, cystic fibrosis, or other lung disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 4. Diabetes: Type (if known) _____   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 5. Cancer  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 6. Epilepsy/seizure disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 7. Disorder of the spine, back, joints, bones  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 8. High blood pressure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 9. Heart disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 10. Stroke, paralysis  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 11. Kidney or bladder disease, kidney dialysis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 12. Liver disease or hepatitis: Type (if known) _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 13. Multiple sclerosis, muscular dystrophy, or cerebral palsy  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 14. Psychological or other mental disorder   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 15. Organ transplant (planned or past)   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 16. Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any autoimmune disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 17. Tuberculosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 18. Colitis or Crohn's disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 19. Any condition or disease not mentioned above, or anticipated surgery                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |

**For each item checked "YES," please explain in section D below.**

**B.** Have any employees, dependents, or COBRA individuals who are eligible for coverage suffered from a condition that resulted in a claim of \$5,000 or more (medical and/or pharmacy) during the last 12 months (excluding pregnancy)?

Yes  No **Please explain in section D.**

Are any employees currently disabled or otherwise not actively-at-work? (Give medical details and date disability started.)

Yes \_\_\_\_\_  No

**C.** Are any eligible employees or dependents currently pregnant?

Yes How many? \_\_\_\_\_ Ages \_\_\_\_\_ Due Dates \_\_\_\_\_  No

