



# Group Medical Questionnaire (51+)

\*Home zip codes are required for all groups with 51 or more employees

Name of Prospect \_\_\_\_\_ Date Completed \_\_\_\_\_

City, State and Zip Code of Headquarter Location \_\_\_\_\_

Broker Name \_\_\_\_\_ Broker Phone/Fax \_\_\_\_\_

Are you the Agent of Record?  Yes  No

Effective Date Requested \_\_\_\_\_ Due Date \_\_\_\_\_

Type of Industry \_\_\_\_\_ SIC Code \_\_\_\_\_

### Plan Information

Is there a group plan currently in place?  Yes  No

If yes, is it an Aetna or NYLCare plan?  Yes  No If yes, group number \_\_\_\_\_

Please provide a **five-year** carrier history, including name of carrier, effective/termination dates, current/prior rates and last rate increase:

Carrier Name	Effective & Term Date(s)	Plan Type	EE	EE/Spouse	EE/Child	Family	Increase %
_____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____
_____	_____	_____	\$ _____	\$ _____	\$ _____	\$ _____	_____

Please identify employer contributions:

EE \_\_\_\_\_ EE/Spouse \_\_\_\_\_ EE/Child \_\_\_\_\_ Family \_\_\_\_\_

### Prospective Group Information

- Total number of eligible employees (including waivers, COBRA, retirees) \_\_\_\_\_
- How many are enrolled in the current plan or are likely to enroll if there is no plan today? \_\_\_\_\_
- Participation \_\_\_\_\_ %
- How many eligible employees not on (or not expected to be on) the company sponsored plan, have spousal or individual coverage? \_\_\_\_\_
- Current number of COBRA Continuees \_\_\_\_\_
- Current number of employees on disability or medical leave \_\_\_\_\_
- How many Union employees are to be covered? \_\_\_\_\_
- What classes are eligible for coverage?  Full Time  Part Time  Retirees  Early Retirees
- If Part time, are contributions the same as full time employees?  Yes  No
- Do all eligible employees work 25 or more hours?  Yes  No
- Retiree plan type if retirees are covered \_\_\_\_\_
- How many Early Retirees are covered? \_\_\_\_\_ and % of total eligibles \_\_\_\_\_ %
- What is reason group is out to bid? \_\_\_\_\_
- Does the group currently have dental coverage? \_\_\_\_\_ yes \_\_\_\_\_ no
- Does the group currently have life coverage? \_\_\_\_\_ yes \_\_\_\_\_ no

Please also provide the following information: Copy of current carrier's plan design, current premium schedule, two year's claims experience, including lives by month, two-year rate history, renewal rates, and large claimant information.

**\*Insurance producers are responsible for verifying that they are appointed for the entity underwriting or administering the health benefit plan.**



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### Medical Profile

Plan sponsor: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than \$25,000 been paid in the last 12 months?  Yes  No

B. Within the past 12 months, has any employee or dependent had a serious continuing claim (i.e., chronic or ongoing condition likely to cost \$10,000 or more per year for treatment) due to a mental or physical disorder?  
 Yes  NO If "Yes," check the appropriate box(es) below.

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> AIDS/Immune Disorders | <input type="checkbox"/> Cardiovascular        | <input type="checkbox"/> Infertility    | <input type="checkbox"/> Neurological        |
| <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Intestines     | <input type="checkbox"/> Pancreas            |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Drug/Substance Abuse  | <input type="checkbox"/> Kidney         | <input type="checkbox"/> Skin                |
| <input type="checkbox"/> Back, Neck            | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Liver          | <input type="checkbox"/> Stomach             |
| <input type="checkbox"/> Blood                 | <input type="checkbox"/> Ears/Eyes             | <input type="checkbox"/> Lungs          | <input type="checkbox"/> Stroke/Paralysis    |
| <input type="checkbox"/> Bone/Joint            | <input type="checkbox"/> Emphysema/Pulmonary   | <input type="checkbox"/> Lupus          | <input type="checkbox"/> Venereal            |
| <input type="checkbox"/> Brain                 | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Mental/Nervous | <input type="checkbox"/> Other, Detail below |
| <input type="checkbox"/> Cancer/Tumor          | <input type="checkbox"/> High Risk Pregnancies | <input type="checkbox"/> Migraines      |  |

C. Are any employees or dependents pregnant?  Yes  No If "Yes," how many? \_\_\_\_\_

If you answered "Yes" to question A or B, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	\$ Amount of Prior Claims	Prognosis / Current Treatment

The information on this form is designed to assist in Aetna's evaluation of your group. The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please Print)	Prospective Applicant Signature	Date
Agent Signature (Existing <input type="checkbox"/> Yes <input type="checkbox"/> No) Date	Sales Representative Signature	Date

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