

HEALTH INSURANCE RISK APPRAISAL

EMPLOYER NAME: _____

GROUP HEALTH INFORMATION:

Please answer the following questions to the **best of your knowledge** and belief for employees and their dependents who are eligible for coverage under your present health plan:

1. Does any eligible employee or dependents including COBRA participants have any of the following conditions? Please list whether the person is an employee or a dependent, age, condition(s), date of onset, surgery performed, current medications, prognosis, and other pertinent information to determine the risk. (no names)

Disease/Disorder of Nervous Systems	<input type="checkbox"/> No	<input type="checkbox"/> Yes	High Blood Pressure/Cholesterol	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Alcohol/Drug Dependency	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart disease/Stroke	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Mental Illness	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Heart bypass surgery	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Kidney Disease	<input type="checkbox"/> No	<input type="checkbox"/> Yes	AIDS/AIDS Related Complex	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Liver Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Obesity	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Immune Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Organ Transplant	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Lung Disease/Disorders	<input type="checkbox"/> No	<input type="checkbox"/> Yes	Stomach Ulcers	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Disease/Disorder of Back/Spine	<input type="checkbox"/> No	<input type="checkbox"/> Yes	(stomach, intestines, colon)		

Yes, details

2. Have expenses in excess of \$5,000 been incurred for any medical treatment during the last 3 years by an individual eligible for coverage? Yes No

Details _____

3. Are you aware of any employee or dependent who has hospitalization, surgery or treatment pending, or who has been advised that hospitalization, surgery or treatment is needed? Yes No

Details _____

4. Are any employees or dependents currently hospitalized or incapacitated due to illness or accident? Yes No

Details _____

5. Are any employees or dependents currently pregnant? Yes No

If yes, please give due date (s).

Employer Signature

Agent's Signature

(Date)