Benefits Questionnaire

Company Name:	
Current Insurance Carrier or PEO:	
How Long Have You Been With Your Current Provider (Carrier or PEO):	

Please answer the following questions to the best of your knowledge. *Please do not disclose the name of any employee or dependent*. Give details to "yes" answers below. Use additional sheets if necessary.

- Are any employees or dependents currently pregnant? If yes, what trimester? ☐ Yes ☐ No
- Are any of the employees currently disabled, hospitalized or not actively at work? ☐ Yes ☐ No
- Did any employee, dependent or COBRA participants incur over $5,000 in claims in the last 12 months? ☐ Yes ☐ No
- Do any employees or dependents have hospitalization, surgery or treatment pending or have been advised that hospitalization, surgery or treatment is necessary? ☐ Yes ☐ No
- Has the company received a Decline to Quote from any carrier or PEO in the past 3 years? ☐ Yes ☐ No
- Have any employees, dependents or COBRA participants been diagnosed or treated for the following conditions (pre-existing conditions)? ☐ Yes ☐ No

  _____ Cancer (Last 5 years) _____ Blood Disorders _____ Stomach Disorder _____ Psychological
  _____ Alcohol / Drug Abuse _____ Heart Conditions _____ Back Problems _____ Diabetes
  _____ Multiple Sclerosis _____ AIDS _____ Muscular Dystrophy
  _____ Other: _____

If you answered 'YES' to any of the above questions, please explain in detail below:

Name of Condition **Date of Diagnosis (mm/yy)** **Treatment / Medication**

_____
_____
_____

Has any employee enrolled in COBRA?_____ (If yes, please list below)

Employee Name **Event Date** **Coverage Level (ee, family)** **Plan Type (HMO, PPO)**

_____
_____
_____

I undersigned hereby certifies that the information in this Medical Questionnaire is correct. In the event that information has been omitted, the insurance carrier may deny or limit coverage for an employee. I certify that all answers and statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind any insurance coverage.

AUTHORIZED REPRESENTATIVE SIGNATURE	PRINT NAME	DATE