

Employer Medical Risk Evaluation Questionnaire

To be completed by the employer and submitted with Application for Group Health Insurance. (For 51+ Employees)

Employer Tax ID Number: 38-_____ Requested Effective Date of Insurance: _____

Employer Name: _____

Current Carrier: _____ Plan Design: _____

Current Rates: EE _____ ES _____ EC _____ F _____

Renewal Rates (attach most recent renewal notice from current carrier): EE _____ ES _____ EC _____ F _____

Employer Contribution Percentage of Premium: EE _____ ES _____ EC _____ F _____

Does your current Health Plan provide you with claims experience? If yes, please include. Yes No

Please answer the following questions:

1. Has any employee or dependent had claims of \$10,000 or more in the last 12 months? Yes No

2. Has any employee or dependent been hospitalized or had surgery within the last 24 months? Yes No

3. Are there any covered employees or dependents who have any existing conditions which may require advice, diagnosis or treatment, surgery or hospitalization? Yes No

4. Is any employee or dependent currently pregnant or have any preterm infants been delivered in the last 12 months? Yes No

5. Check below if any employees or dependents received treatment during the last 5 years for any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Brain Disorders (e.g. Multiple Sclerosis or Epilepsy) |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease (e.g. Cirrhosis or Hepatitis) |
| <input type="checkbox"/> Heart or Blood Disease | <input type="checkbox"/> Auto-immune Disease (e.g. Rheumatoid Arthritis or AIDS) |
| <input type="checkbox"/> Diabetes | |

6. Has any employee requested an FMLA leave or been on short-term disability or long-term disability or been absent from work due to an illness or injury for more than five (5) consecutive working days within the last 12 months? Yes No

If yes, please list (attach additional list, if needed)

List E for Employee D for Dependent	Year Illness, FLMA Leave or Disability Began Began Returned or Ongoing	Type of Illness, Injury or Disability

7. Are any former employees or dependents currently on, or eligible for, continuation under COBRA*? Yes No

If yes, please list employees and dependents (attach additional list, if needed)

List E for Employee D for Dependent	Year Illness, FLMA Leave or Disability Began	Type of Illness, Injury or Disability

* Individual health questionnaires may be requested on COBRA participants, disabled individuals or serious medical conditions. Please provide details for "yes" answers to the questions 1 through 5. (If more space is needed, attach additional list.)

Question #	List E for Employee S for Spouse C for Child	Condition/Medication	Years of Treatment	Estimated Dollar Amount of Claims	Prognosis/ Current Treatment

We declare that the information on this form is true and accurate to the best of our knowledge. We understand that it will be used as a basis for underwriting our Group Health Plan.

We also understand that the submission of false or misleading information may result in the adjustment of rates back to the original effective date or the immediate termination of the group and/or employee.

Employer's Signature Title Years with Company

Agent Insurance Agency Date

Gatekeeper (If different from Employer or Agent) Title

Large Group Employer Application

For 51+ Eligible Employees

Employer _____ Tax ID# _____
 SIC _____ Worker's Comp Carrier _____
 Street _____
 City _____ County _____ State _____ ZIP _____
 Billing Address (if different) Street _____
 City _____ County _____ State _____ ZIP _____
 Telephone Number () _____
 Nature of Business _____
 President/CEO Telephone Number () _____
 Contact Person _____ Title _____
 Telephone Number () _____ Fax Number () _____ Email _____

Employer Contributes % of Premium or Dollar Amount as follows:

	Life	Dependent Life	WI	Health/Rx	Dental	Vision
Single						
Parent & Child						
Couple						
Family						

Premium Submitted \$ _____

Other Affiliates or Subsidiaries Included or Excluded

Name and Address	Include or Exclude
1. _____	_____
2. _____	_____
3. _____	_____

Previous Insurance Carrier _____

Health Deductible _____	Co-Insurance _____	Effective Date _____	Paid to Date _____
Dental Deductible _____	Co-Insurance _____	Effective Date _____	Paid to Date _____

Proposed Effective Date: ____ / ____ / ____
Mo Day Yr

Waiting Period for New Employees

30, 60, or 90 days _____
 Other _____

Effective Date for New Employees

1st day after waiting period _____
 1st of month after waiting period _____

Number of Employees	Number of Employees Insured for	Number of Employees Waiving Coverage	Number of Employees on Continuation of Coverage
Full Time _____	Life/AD&D _____	Life/AD&D _____	COBRA _____
Part Time _____	Dependent Life _____	Dependent Life _____	State _____
Retired _____	Health _____	Health _____	USERRA _____
Are retirees covered under this plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental _____	Dental _____	
	Vision _____	Vision _____	
Contract or leased _____	WI _____	WI _____	
Total _____			

In addition to this health plan, will your company provide supplemental health coverage, that is, either a self-funded or insurance program that helps cover all or part of the employee's deductible under the primary health coverage? Yes No

The Employer understands and agrees that:

1. No insurance will become effective without the written approval of American Community.
2. The eligibility, participation requirements, pre-existing conditions provision and cost-containment/PPO requirements have been discussed with and explained by an American Community representative or the agent.
3. This application shall become a part of the contract issued by American Community.
4. All known ongoing serious illnesses and/or large claims (exceeding \$10,000) in the last 2 years have been disclosed to the agent and American Community.
5. Any incomplete, incorrect, or misleading answers may void the insurance contract at American Community's option.
6. The employer will be required to sign the final acceptance of benefit selection, rates and effective date of coverage.

Dated at

Date

Employer's Authorized Signature

Witness (Licensed Resident Agent's Signature)

Agent's Number

Agent's Name (Print)

Agent's Phone Number

Agent's Fax Number

Legal Notice

Returned Check Fee: For groups issued in all states, **except** Nebraska, if any premium payment made directly by check is returned for nonsufficient funds, a \$20 nonrefundable service fee will be applied. This fee will be due with your next premium payment.

Ohio residents: Any person who, with intent to defraud or knowingly facilitates a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania residents: We are required by Pennsylvania law to inform you of the following: "Any person who, knowingly and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties."

Group Employee Non-Medical Application



Employer Name _____ Group # _____

Employee Name _____ Division/Location _____

A. EMPLOYEE PERSONAL INFORMATION

Home Address		City		State	Zip Code
Phone	Email	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Occupation	Full-time Date of Hire / /	Average hours per week:
Wage/Salary \$ per	How is income reported to IRS? (Note: 1099 employees are not eligible) <input type="checkbox"/> W2 <input type="checkbox"/> Other _____		Employee Status: <input type="checkbox"/> Active <input type="checkbox"/> Rehired <input type="checkbox"/> Retired <input type="checkbox"/> COBRA <input type="checkbox"/> USERRA ____/____/____ Qualifying date		
If COBRA, date of qualifying event ____/____/____					
Nature of event: <input type="checkbox"/> Termination <input type="checkbox"/> Retirement <input type="checkbox"/> Divorce <input type="checkbox"/> Reduction in hours <input type="checkbox"/> No longer eligible <input type="checkbox"/> Other _____					
Reason for Enrollment: <input type="checkbox"/> New Group <input type="checkbox"/> New Hire <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Change in coverage or status					

B. EMPLOYEE AND DEPENDENT INFORMATION (List only those dependents applying for coverage)

Relationship	Name (First, MI, Last)	SSN:	Height	Weight	Sex	Birth Date	Full time student?	Home Office Use Pre-Ex
Employee					M F	/ /		
Spouse					M F	/ /		
Child					M F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
Child					M F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No	
Child					M F	/ /	<input type="checkbox"/> Yes* <input type="checkbox"/> No	

*Children over age 19, list school and number of credit hours _____

C. COVERAGE SELECTIONS AND WAIVERS

Please indicate which eligible coverage(s) you are choosing:	Medical: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)
	Dental: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)
	Vision: <input type="checkbox"/> Employee <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Employee/Spouse/Child(ren)
Deductible Option (if plan has more than one option) _____ Network Option (if plan has more than one option) _____	

I certify that I was given the opportunity to apply for group benefits offered by my employer through American Community and I do not accept the offer.

- I waive **Medical** coverage for: Myself and my dependents My spouse only My children only
 I waive **Dental** coverage for: Myself and my dependents My spouse only My children only
 I waive **Vision** coverage for: Myself and my dependents My spouse only My children only

I am declining coverage due to existence of other coverage: Spouse's Employer Plan Parent's Plan Individual Plan
 Medicare Medicaid COBRA from prior employer VA Eligibility Tri-Care Other _____
 I (we) have no other coverage at this time.

Home Office Use Only		
Endorsement	TA LE LOSS OPEN CLAPP MEDS N/A DOH _____ Affiliation Period (MI) _____ Issue State _____ Waiting Period _____ App Signed _____	LF/AD _____ Dependent Life WI _____
Medical	RX	M/O
None	S C P F	
Dental		
None	S C P F	
VS/EX only		
None	S C P F	
Group #	Certificate #	Effective Date

D. OTHER COVERAGE SECTION

<p>Previous Coverage: Within the last 18 months, did you have health insurance coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, who was covered? _____</p> <p>Insurance Company Name: _____</p> <p>Phone# _____ Policy _____</p> <p>Effective Date _____ End Date _____</p>	<p>Concurrent Coverage: Will you, your dependent or spouse keep other health coverage in addition to this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, who is covered? _____</p> <p>Insurance Company Name: _____</p> <p>Phone# _____ Policy _____</p> <p>Effective Date _____</p>
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E. LIFE/AD&D BENEFICIARY DESIGNATION

Beneficiary _____ Relationship _____ SSN _____

F. EMPLOYEE AGREEMENT/CONSENT

Consent: I consent to any physician, hospital, clinic, pharmacy, other medical or medically related facility, insurance company, health information repository to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers, any information, record or knowledge of the health of any persons proposed for insurance to carry out treatment, payment or health care operations. This consent includes information about drug and alcohol abuse and psychiatric conditions but does not provide for the release of psychotherapy notes. I consent to any consumer reporting agency that has any record, public record or knowledge of the character, general reputation, personal characteristics and mode of living, of any persons proposed for insurance to give to American Community Mutual Insurance Company, its legal representatives or its reinsurers any such record or knowledge for purposes of underwriting insurance. This consent does not allow a consumer reporting agency to release health information. A photographic copy of this consent shall be as valid as the original for 24 months from the date below. I know that I, or my authorized representative may request and am entitled to receive a copy of this consent.

I acknowledge that I have been provided with a Notice of Your Privacy Rights, which provides a complete description of how my protected health information may be used or disclosed.

Contribution: I am aware that I am required to contribute toward the cost of my insurance premium as indicated by my employer. I authorize my employer to deduct my portion of the premium for this insurance from my pay.

Disclosures: I understand no insurance exists unless and until my employer received notification in writing from American Community's Home Office indicating coverage for me and my dependents and the effective date. If, prior to such notification, anyone applying for coverage under this application consults a doctor, is hospitalized or has a change in health, I agree to inform American Community immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application nor any provisions, terms or conditions of any other forms or materials supplied by American Community, nor bind American Community to any promise of coverage.

Representations

I represent that all statements and answers are true and complete to the best of my knowledge. I understand and agree that omissions, misrepresentation or misstatements may be used to deny a claim or terminate coverage if such information materially affects the degree of risk. **Any person who, with intent to defraud, submits an application or files a claim containing a false statement may be guilty of insurance fraud.**

G. SIGNATURE REQUIRED (THIS FORM MUST BE SIGNED AND DATED)

Signature of Key Applicant or personal representative	Relationship to applicant or representative's authority to act for applicant	Date	Signed at: City and State
Signature of Spouse	Relationship to applicant or representative's authority to act for applicant	Date	Signed at: City and State