



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.

I. GENERAL INFORMATION					
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.					
II. GROUP ELIGIBILITY					
Total Employees: _____ = Full-time: _____ + Part-Time: _____; COBRA Continuees _____ Retirees _____					
Total Eligible Employees: _____ = Currently Covered _____ + Cobra Eligible _____ + 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					
Please see your WP/CHL rate proposal for complete eligibility and quoting policies.					
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.					
• Full-time, actively at work employees with Medicare (include effective dates for Part A and B).					
• 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.					
III. COVERAGE INFORMATION (List all health carriers in the last five years)					
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 or Peripheral Vascular disease (diseases of the blood vessels outside the heart) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 10. Bleeding, clotting or blood disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 11. Stroke, paralysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 12. Kidney or bladder disease, kidney failure or on dialysis | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 13. Liver disease, cirrhosis or Hepatitis: Type (if known) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 14. Multiple sclerosis, muscular dystrophy, or cerebral palsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 15. Psychological or other mental disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 16. Organ transplant (planned, recommended or has already taken place) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 17. Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or any autoimmune disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 18. Ulcerative Colitis, Crohn's disease, or stomach ulcers | <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? Are there any "over-aged dependents" to be covered due to disability? (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

