

Group Health Risk Questionnaire

Employer: For all employees and dependants, please answer the following questions to the best of your knowledge (to include proprietors, partners, and corporate officers.) Please provide details to all "Yes" answer in the space provided below.

Group Name: _____

HEALTH/WELLNESS PROMOTION		
1. Do you offer a smoke-free workplace?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you offer injury prevention classes such as back care, repetitive motion disorders, proper lifting and use of heavy equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Do you have a drug/alcohol screening program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Please check any of the following your company provides:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> cholesterol screenings <input type="checkbox"/> on-site flu shots		
<input type="checkbox"/> blood glucose screenings <input type="checkbox"/> blood pressure checks		
ADVERSE RISK FACTORS		
5. How many participants or covered dependents are pregnant?	_____	
6. Has any participant or covered dependent been treated for or is expected to be treated for a serious illness or injury (e.g., cancer, AIDS, substance abuse, juvenile diabetes, cardiovascular diseases, mental illness, multiple sclerosis, rheumatoid arthritis, renal disease, pulmonary disease, etc.), been hospitalized or had surgery in the past 12 months, or is expected to be hospitalized or is expecting to undergo surgery in the next 12 months? If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ _____ _____		
7. Has any employee or dependent been rated or declined for group life or medical insurance under your present or prior group plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. How many persons are presently covered under the Continuation of Medical Benefits as defined under COBRA who will probably continue coverage under this plan?	_____	
9. Has any participant or covered dependent had in the past 12 months or expect to have in the next 12 months a health claim of \$5,000 or more? If you are unsure as to the cost of the individual's potential medical expenses, please list the conditions to the best of your knowledge. If so, please clarify with dates, diagnosis, prognosis, follow-up care, on-going treatments, etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____ _____ _____		

Broker Signature	Group Representative Signature
------------------	--------------------------------