PEO SOURCE

WE ARE YOUR ADVOCATES TO THE PEO INDUSTRY.

Group Health Questionnaire

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable.
We will not accept the questionnaire if incomplete. Use additional paper if necessary.

Date _____ Proposed Effective Date: _____

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
Company Name					
Street Address					
City		**State**		**Zip**	
County		**Benefits Contact & Phone #**			
Total Number of employees on payroll:		**Total Full Time:** **Total Part Time:**	**Total Number of employees currently enrolled in health care plan:**		
Are any health plan enrollees NOT paid employees (other than spouses or children?) ☐ YES ☐ NO *****If yes, please provide names and details:**					
Current Health Carrier:		**Health Carrier Renewal Date:**			
Is your current Plan Self-Funded? ☐ YES ☐ NO **Don't Know ***If yes, please provide claims.**					
Are you currently with a PEO? ☐ YES ☐ NO **If yes, name of PEO:**		**Any ineligible class of employees** ☐ YES ☐ NO **If yes, which class:**			
Please provide a complete description of your business operation:			**SIC Code:**		
Number of Locations: _____		**Please identify all states of operation:** _____			

A. List any current COBRA / State Continuation participants: ☐ **NONE**

Name / DOB / Phone # of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)
-	-	-
-	-	-
-	-	-

B. List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date: ☐ **NONE**

Name / DOB / Phone # of Individual	Date Eligible	Activating Event/Date
-	-	-
-	-	-
-	-	-
-	-	-

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II. CURRENT PLAN CONTRIBUTION INFORMATION
(Does your company have more than one Contribution Level? If so, please list each separately)

	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels ($ or %)				
Company Contribution Levels ($ or %)				

III. RATE HISTORY & PLAN DESIGN DETAILS (include the 3 most elected plans)

Plan 1 Name:_____	**# Enrolled**	**Renewal Rates (eff.__ __ ____)**	**Most recent 12 months**	**13-24 Months Prior**	
		Premium Rates			**Plan Design Details**
Employee Only	#	$	$	$	Annual Deductible $ _
Employee + Spouse	#	$	$	$	Co-Insurance % _
Employee + Child(ren)	#	$	$	$	Out of-Pocket Max$ _ (excluding ded.)
Employee + Family	#	$	$	$	Office Visit Copay $ _____
					Prescription Drugs $_____

Plan 2 Name:_____	**# Enrolled**	**Renewal Rates (eff.__ __ ____)**	**Most recent 12 months**	**13-24 Months Prior**	
		Premium Rates			**Plan Design Details**
Employee Only	#	$	$	$	Annual Deductible $ _
Employee + Spouse	#	$	$	$	Co-Insurance % _
Employee + Child(ren)	#	$	$	$	Out of-Pocket Max$ _ (excluding ded.)
Employee + Family	#	$	$	$	Office Visit Copay $ _____
					Prescription Drugs $_____

Plan 3 Name:_____	**# Enrolled**	**Renewal Rates (eff.__ __ ____)**	**Most recent 12 months**	**13-24 Months Prior**	
		Premium Rates			**Plan Design Details**
Employee Only	#	$	$	$	Annual Deductible $ _
Employee + Spouse	#	$	$	$	Co-Insurance % _
Employee + Child(ren)	#	$	$	$	Out of-Pocket Max$ _ (excluding ded.)
Employee + Family	#	$	$	$	Office Visit Copay $ _____
					Prescription Drugs $_____

Attach a copy of your benefit summary for each plan and year listed above. Include carrier claims report if available.

Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

IV. SERIOUS ILLNESS / CONDITION QUESTIONS:

	To the Best of My Knowledge
A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?	☐ YES ☐ NO
B. Is anyone currently hospitalized, confined at home, incapacitated, confined, orin a treatment facility, incapable of self-support because of physical or mental disability?	☐ YES ☐ NO
C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? *(If yes to any, please provide details in the table below.)*	☐ YES ☐ NO

D. Is anyone currently being treated or been advised to seek treatment for any of the following?

Please check all that apply:

☐ AIDS or testing HIV Positive
☐ arthritis
☐ back disorder
☐ cancer
☐ diabetes
☐ heart disease
☐ kidney disorder
☐ liver disease
☐ mental illness
☐ muscular disorder
☐ nervous system disorders
☐ respiratory disease
☐ stroke
☐ substance dependency
☐ transplants
☐ tumor
☐ other serious conditions

(For all checked boxes, please provide details below)

Name	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

E. List any employees and/or dependents that are on the health plan that are disabled:

☐ **NONE**

Name	Disability	Qualifying Event
-	-	-
-	-	-
-	-	-

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F. Is Anyone Currently Pregnant?	☐ YES ☐ NO

In the event that information has been omitted or is inaccurate, the insurance carrier may deny or limit coverage for an employee and PEO may terminate any service agreement for breach. In such cases, the client may be liable to the PEO or an employee for any damages. The PEOs gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight. Because actuarial analysis requires current, accurate information, this questionnaire expires after 60 days from the date signed below. After that time, a new questionnaire will be required.

I certify that the 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 coverage. I will notify the PEO of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage with the PEO.

The Program Notice of Privacy Practices provides more detailed information about how the PEO and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The PEO's Incorporated Program and my health plan are not required by law to grant my request. However, if my request is granted, the PEO's Incorporated Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the PEO.

Authorized Signature ***Title*** ***Date***

Print Name ***Print Name of Company***