

## Employer Group Health Questionnaire

This questionnaire is designed to provide information specific to your group and will be used 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: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_  
 Billing Contact Person: \_\_\_\_\_  
 Billing Contact Email: \_\_\_\_\_  
 Home Office Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ # of Years In Operation: \_\_\_\_\_  
 Type of Business: \_\_\_\_\_  
 Standard Industry Code (SIC): \_\_\_\_\_ Federal Tax ID#: \_\_\_\_\_  
 Requested Effective Date: \_\_\_\_\_

### II. GROUP DATA

1. Total Employees: Full-Time \_\_\_\_\_ Part-Time \_\_\_\_\_ COBRA \_\_\_\_\_
2. Total Eligible Employees: \_\_\_\_\_ Total Employees Waiving Coverage: \_\_\_\_\_
3. Employer Contribution: Employee \_\_\_\_\_ Dependent \_\_\_\_\_
4. Waiting Period For New Hires:
  - Effective date is 1<sup>st</sup> of month following date of hire
  - Effective date is 1<sup>st</sup> of month following 1 month of continuous employment
  - Effective date is 1<sup>st</sup> of month following 2 months of continuous employment
  - Effective date is 1<sup>st</sup> of month following 3 months of continuous employment

5. If there are locations other than indicated above, please provide the following details:

City	State	Zip	# of EE'S

6. Are all eligible employees covered by Workers Compensation?  Yes  No  
 If no, please explain: \_\_\_\_\_

### III. PLAN INFORMATION

1. Please list all health carriers for the past 5 years:

Carrier	From	To	Reason for Termination

2. Please provide current and renewal rates for all plan(s) currently offered:

Plan 1 (Please Provide Plan Details): \_\_\_\_\_

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

Plan 2 (Please Provide Plan Details): \_\_\_\_\_

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

Plan 3 (Please Provide Plan Details): \_\_\_\_\_

	Effective Date	EE Only	EE/Sp	EE/Ch(ren)	Family
Current					
Renewal					

**IV. ADDITIONAL INFORMATION REQUIRED**

- Census** – Please complete all columns of the attached census form. Spreadsheet must be submitted via email.
- Benefit Plan Summaries** – Please provide current benefit summaries.
- Statements of Health (Only if Claim information is not available)** - Attach a SPMIC Group Health and Dental application for each eligible employee (including those on state continuation or COBRA), including his/her covered dependents.
- Claim and Enrollment Experience (Current plan year and past two plan years if available from carrier)\***  
**\*\*If unavailable from carrier, please provide current rates and past 2 years rates and corresponding plan designs**
- State Wage and Tax Statement** – Attach a copy of your most recent state wage and tax statement.
- Current Bill** – Attach a copy of the most recent monthly bill from your current carrier.
- SPMIC Disclosure Statement** – Groups not submitting individual applications need to complete in full and sign (see attached).

**Self Funded Groups Only**

- Self Funded Groups Only (Self funded groups do not need to provide Current Bill and State Wage and Tax Statement.)** Please provide the following Claim information:
  - Aggregate report from the carrier - current plan year and past two plan years
    - Lists the claims paid by month and enrollment by month
  - Specific report from the carrier – current plan year and past two plan years

- Lists the participants with paid claims in excess of 50% of the specific deductible
- Detail needed for participants on current specific report - (if known):
  - Medical condition (diagnosis)
  - If treatment is complete or on-going
  - Date of service (month and year) that large portion of the medical services were rendered. (For example the month and year of the surgery, accident, etc...)

**Stop Loss Information (Current plan year and past two plan years)**

- Specific Stop Loss Coverage
  - Single and family monthly specific premium
  - Contract type (Paid, 24/12, 18/12, 15/12, etc...)
  - Is prescription drug coverage currently covered under the specific contract?
- Aggregate Stop Loss Coverage
  - Aggregate monthly premium
  - Monthly claim factors
  - Contract Type
  - Is prescription drug coverage currently covered in the aggregate contract?

**V. STATEMENT OF UNDERSTANDING**

**I understand and do hereby certify that the information contained in this Employer Group Health Questionnaire is complete and accurate to the best of my knowledge.**

Signature: \_\_\_\_\_  
(Company Executive or Senior Human Resource Employee)

Date Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone #: \_\_\_\_\_

## SystemsPlus Mutual Insurance Company – Disclosure Statement

Full Legal Name of Applicant/Named Insured \_\_\_\_\_

***This form must be completed by the named insured (Employer) no earlier than 45 days prior to the effective date and returned to SPMIC within 5 days of completion by the named insured. Coverage will be automatically rescinded if the signed disclosure statement is not completed and returned to SPMIC within 30 days following the proposed effective date. All information will be treated as confidential. Should we require any additional information in order to accept this disclosure statement, we will respond in writing no later than 20 days following receipt of this document.***

Please answer each question below. If the answer is yes to any part, please provide details below or attach another sheet, if necessary. "Participant" means any eligible employee, COBRA participant or their dependents.

Have claims on any participant during the last 12 months been incurred and/or paid in excess of \$25,000?  Yes  No

Are any participants currently, or have they been in the past 30 days, confined to a hospital or other medical facility on multiple occasions or for three (3) or more consecutive days?  Yes  No

Are there currently any dependent children over the normal termination age covered by the plan under a disabled or handicapped child extension provision?  Yes  No

Other than the individuals already listed, are there other known potential shock loss claims? (Potential catastrophic claims means any claimants expected to incur claims that may reasonably be assumed will exceed \$25,000 in the next plan year.) Shock losses are defined on the second page along with a "Trigger" Listing. ***(The Trigger Diagnosis List is intended to assist the Named Insured in their disclosure review.)***  Yes  No

Last Name, First	Diagnosis/Prognosis	Mo./Yr. 1 <sup>st</sup> day for Treatment	Last 12 Months Paid Claims Amount	Pended/Denied Claims Amount
1.				
2.				
3.				
4.				

Are there any participants who are expected to be absent from work due to disability on the effective date of the Stop Loss Policy coverage?  Yes  No

Have any participants been absent from work due to disability (sick time, Family Medical Leave, or scheduled Leave of Absence) during the past 30 days? (In the case of a dependent or COBRA participant, is by disability unable to perform his or her normal functions of a person of like sex and age.)  Yes  No

Disabled Lives	Status/Reason for Disability
1.	
2.	
3.	

7. Are any participants covered under COBRA or COBRA eligible?  Yes  No

COBRA Participants	Qualifying Event and COBRA Start Date
1.	
2.	
3.	



## **Suggested Categories and Guidelines for Identifying Potential Large Claims**

The specific diagnoses listed below are key indicators of potential catastrophic cases and should be referred to SPMIC. The following instances should also be explored for potential case management.

### **Transplants**

**A length of stay request more than seven (7) days**  
**Trauma/Multiple Injuries**  
**Request for transfer to a rehabilitation facility**

### **AIDS**

Human Immunodeficiency Virus  
 Encephalopathy  
 Pneumocystis Carinii Pneumonia  
 Toxoplasmosis  
 Bronchial or Pulmonary Candidiasis  
 Tuberculosis

### **Blood Disorders**

Aplastic Anemia  
 Coagulation Defects  
 Immune Deficiencies

### **Amputations**

Arms and Hands  
 Legs and Feet

### **Burns**

Over 20% of the Body

### **Cardiovascular Disease**

Cardiomyopathy  
 Heart Failure  
 Intermediate Coronary Syndrome  
 Primary Pulmonary Hypertension

### **Cerebral Vascular Disease with Neurological Deficits**

Anoxic Brain Damage  
 Multiple Fractures, Skull/Face  
 Intracerebral Hemorrhage  
 Coma  
 Acute Vascular Disease (Stroke/CVA)

### **Home IV antibiotic therapy**

**High Risk Pregnancy (Multiple Births)**  
**Initiation of hemodialysis**

### **Infectious Diseases**

Meningitis  
 Subacute Bacterial Endocarditis  
 Crohn's Disease  
 Osteomyelitis

### **Malignant Neoplasms -Any Site**

Cancers  
 Neurofibromatosis

### **Diabetes Mellitus Complications**

Circulatory Disorders  
 Amputations

### **Head and Spinal Trauma**

Quadraplegia  
 Paraplegia  
 Hemiplegia  
 Spinal Cord Injury  
 Closed Head Injury  
 Complications of trauma

### **Neuromuscular**

Amyotrophic Lateral Sclerosis  
 (Lou Gehrig's disease)  
 Myopathy  
 Guillain-Barre  
 Cerebral Palsy  
 Multiple Sclerosis

### **Renal Failure**

### **Hyperalimentation (TPN)**

**SystemsPlus Mutual Insurance Company – Disclosure Trigger/Diagnosis**

## Suggested Categories and Guidelines for Identifying Potential Large Claims

The specific diagnoses listed below are key indicators of potential catastrophic cases and should be referred to SPMIC. The following instances should also be explored for potential case management.

### High-Risk Neonatal

Intestinal Malabsorption  
 Spina bifida  
 Other congenital anomalies of nervous system (includes hydrocephalus)  
 Congenital anomalies of heart  
 Short gestation, low birth weight <2,500g  
 Intrauterine hypoxia and birth asphyxia  
 Respiratory Distress Syndrome  
 Apnea/Bradycardia  
 Broncho-Pulmonary Dysplasia (BPD)  
 Cystic Fibrosis  
 Biliary Atresia

### Other

Gaucher's Disease  
 Cirrhosis of the liver  
 Emphysema  
 Morbid Obesity  
 Alpha-1 Antitrypsin Deficiency  
 Post-inflammatory Pulmonary Fibrosis  
 Hepatitis  
 Pancreatitis  
 Lupus  
 Aneurysm

### High Risk Obstetrical

Multiple Gestations  
 Premature Rupture of Membranes

The specific procedures listed below are key indicators of potential catastrophic cases and should be referred to SPMIC. Transplants should be referred to our Transplant Solutions team for cost containment assistance prior to transplantation.

### Procedures

Craniotomy  
 Hyperbaric Oxygenation  
 Plasmapheresis (Apheresis)  
 Laryngectomy/Radical Neck Dissection  
 Tracheostomy  
 Implant Cardiac Assist Device  
 Hemodialysis  
 Pancreatectomy  
 Ventilator patient greater than 4 days  
 Insertion shunt fistula  
 Gastric Bypass  
 TPN (Total Parenteral Nutrition)  
 Transplants

### Transplant Type

Bone Marrow Transplant  
 Heart  
 Heart-Lung  
 Small Bowel  
 Liver  
 Lung (single)  
 Lung (double)  
 Pancreas  
 Kidney