Marketed and Administered Exclusively by:
GBS Group Benefit Services
6 North Park Drive Suite 310 ◆ Hunt Valley, MD 21030
Phone: (410) 832.1300 ◆ 1 (800) 638.6085
Web: http://www.gbsio.net

Employer Group Health Questionnaire

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 the 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 participants in COBRA/State Continuation (use additional paper if necessary):

☐ NONE

Name 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 participants who will become eligible for COBRA prior to the Health Plan effective date (use additional paper if necessary):

☐ NONE

Name of Individual	Date Eligible	Activating Event/Date

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

☐ NONE

Name of Individual	Disability	Qualifying Event

II. RATE HISTORY (If more than 3 plans, include the 3 most popularly-elected plans)				
Plan 1 Name:	# Enrolled:	Renewal Rates Eff.	Most Recent 12 Months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 2 Name:	# Enrolled:	Renewal Rates Eff.	Most Recent 12 Months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 3 Name:	# Enrolled:	Renewal Rates Eff.	Most Recent 12 Months	13-24 months prior
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION (Individual, in-network only)			
Current Plan Names:	1.	2.	3.
Current Plan Types:	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ Other	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ Other	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ Other
Annual Deductible			
Coinsurance as %			
Out-of-Pocket Max (excluding deductible)			
Office Visit Copay			
Prescription Drug Copay Generic/brand formulary/ brand non-formulary			

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
Company Contribution Levels (by $ or %)				

*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.

GENERAL ILLNESS QUESTIONS	TO THE BEST OF MY KNOWLEDGE (ANY OR ALL)
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 in 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?	☐ Yes ☐ No
(*If yes to any or all, please provide details in the table below)*	

SPECIFIC ILLNESS QUESTION:
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	☐ Kidney Disorder	☐ Stroke
☐ Arthritis	☐ Liver Disease	☐ Substance Dependency
☐ Back Disorder	☐ Mental Illness	☐ Transplants
☐ Cancer	☐ Muscular Disorder	☐ Tumor
☐ Diabetes	☐ Nervous System Disorders	☐ Other Serious Conditions:
☐ Heart Disease	☐ Respiratory Disease	

(If any boxes are checked, please provide details in the table below.)

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

Known Medical Conditions to the best of your knowledge (continued):

IS ANYONE CURRENTLY PREGNANT?	To the Best of My Knowledge:
If yes, please provide due date and note below if normal, high risk, multiple birth, or preterm labor with this pregnancy. *This includes employees, dependents or COBRA participants*	☐ Yes ☐ No

Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc).

I certify that the statements herein 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 entity collecting this information of any changes that occur after signing this Group Health Questionnaire and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement may be terminated for breach. In such cases, my company may be liable to Milliman or an employee for damages.

This information is gathered 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.

In compliance with requirements for GINA, the entity collecting this information is not requesting genetic information. No information regarding the height or weight of any Michigan employees has been provided.

Authorized Signature	Title	Date
Print Name	Print Name of Company	
Broker/Sales Signature	Broker/Sales Print Name	Date

Client Privacy Notification

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detail health information (protected health information) that you provide via hard copy or through the Milliman, Inc. HERO Online Data Collection Website will be used solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), association group (Association) or Trust that will provide a health insurance quote to the employer. Milliman is acting as a Business Associate to the PEO/MEWA/Association/Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations. Milliman will not sell, license, transmit or disclose this information outside of Milliman unless: a) necessary for Milliman to provide the services on behalf of the PEO/MEWA/Association/Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.