

**Employer Risk  
 Appraisal Questionnaire  
 Groups 51+ Employees**

This questionnaire is designed to provide information specific to your group and will be used by HealthAmerica and HealthAssurance 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

**II. 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 been diagnosed or treated by a provider for any of the following conditions within the last 5 years?

**(Please check Yes or No. If yes, please circle all conditions that apply.)**

- |  |                              |                             |                    |
|--|------------------------------|-----------------------------|--------------------|
| 1. Cancer: Type (if known)_____                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 2. Heart disease   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 3. Organ transplant (planned or past)                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 4. Arthritis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 5. Asthma, emphysema, cystic fibrosis,<br>or other lung disease  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 6. Diabetes: Type (if known)_____                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 7. Epilepsy/seizure disorder                                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 8. Disorder of the spine, back, joints, bones                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 9. Stroke, paralysis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 10. Kidney or bladder disease, kidney dialysis                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 11. Liver disease or hepatitis:<br>Type (if known)_____          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 12. Multiple sclerosis, muscular dystrophy, or<br>cerebral palsy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 13. Psychological or other mental disorder                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 14. HIV/AIDS   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 15. Tuberculosis   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |
| 16. Colitis or Crohn's disease                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | # of people: _____ |

17. Any condition or disease not mentioned

above, or anticipated surgery

Yes  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 incurred claims that have exceeded \$10,000 (medical and/or pharmacy) during the last 12 months?

Yes  No **Please explain in section D.**

Are any employees currently disabled or otherwise not actively-at-work? (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

**D.** Please explain any "YES" answers in this space. Please indicate what question you are answering. **If more space is needed, attach a separate sheet. Please sign and date all attachments.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. STATEMENT OF UNDERSTANDING**

I understand and do hereby certify that the information contained in this Employer Risk Appraisal Questionnaire is complete and accurate to the best of my knowledge. I further certify that I hold a position with the company that permits me to have the information necessary to complete this Employer Risk Appraisal Questionnaire on behalf of the company or I have conferred with and confirmed my answers with person(s) that hold such position(s) with the company. It is further understood that HealthAmerica and HealthAssurance reserve the right to re-rate or rescind coverage if any supplied information is an intentional misrepresentation of a material fact.

I understand that HealthAmerica and HealthAssurance may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that HealthAmerica and HealthAssurance may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify HealthAmerica and HealthAssurance for any liability or damages resulting from any breach of representation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by employer.

Signature \_\_\_\_\_ Print Name \_\_\_\_\_  
(Company executive or senior Human Resources employee) Title \_\_\_\_\_  
Phone number \_\_\_\_\_ Date Signed \_\_\_\_\_

HealthAmerica HMO and HealthAssurance HMO products are made available through HealthAmerica Pennsylvania, Inc. HealthAssurance PPO and CCPPO (POS) are made available in Pennsylvania through HealthAssurance Pennsylvania, Inc. and in Ohio through Coventry Health and Life Insurance Company d.b.a. HealthAssurance. Out-of-area products are made available through Coventry Health and Life Insurance Company d.b.a. HealthAssurance. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

THE COMPANY UNDERSTANDS AND AGREES THAT THIS RISK ASSESSMENT QUESTIONNAIRE IN NO WAY OBLIGATES HEALTHASSURANCE TO OFFER GROUP HEALTH INSURANCE TO THE COMPANY. FURTHER, COVERAGE MAY BE RESCINDED IF THERE ARE MISSTATEMENTS, FRAUDULENT OR OTHERWISE IN THIS QUESTIONNAIRE.