EMPLOYER GROUP INFORMATION

Indicate N/A in any sections that do not apply to your group.

BlueCross BlueShield of Illinois

SECTION A

Employer Name_____ Employer Tax ID #_____

Type of Business_____SIC Code_____ Original Business Start-up Date_____/_____/_____

Parent Company Name _____

Prior Group Coverage with Blue Cross and Blue Shield of Illinois. a Division of Health Care Service Corporation, a Mutual Legal Reserve Company? ☐ Yes ☐ No **If Yes**, provide Cancellation Date_____ & Group Number _____

Is the Group's current funding arrangement fully insured? ☐ Yes ☐ No

What is the Group's current health coverage renewal date? _____/_____/_____

Number of Part-Time Employees:_____ Number of Full-Time Employees:_____ Number of Total Employees:_____	Number of Out-of-State Resident Enrollees: _____ List: State / Number of Employees _____ _____ _____ _____ _____ _____	Total Number Enrolled: _____ Number with Signed Waivers: _____

List below the names and termination dates for Employees, Spouses and/or Children continuing coverage under the provisions of **COBRA, or Illinois Continuation** (will be referenced only as COBRA throughout remainder of this form).

Name of COBRA Continuee	Coverage Type (Individual or Family)	Projected COBRA Termination Date	Type of Coverage Extended
			☐ Health ☐ Dental
			☐ Health ☐ Dental
			☐ Health ☐ Dental

List below the names of **covered Employees not actively at work** due to: 1) layoff; 2) leave of absence; 3) confinement in a health care facility; 4) maternity leave; 5) disability; 6) worker's compensation; 7) illness; 8) injury; 9) other (specify)_____

Employee Name	Age	Reason for Absence (1-9)	Plan Type (PPO, HMO, etc.)	Date Last Worked	Family Coverage (Y or N)

List below all **disabled** Spouses and/or Children who are currently covered by the group health plan.

Spouse or Child Name	Age	Employee Name	Plan Type (PPO, HMO, etc.)	Date of Disability	Will BCBSIL be Primary or Secondary?	Medicare Eligible (Y or N)

SECTION B

This section is to be completed by groups with 51 or more employees *ONLY*.

MEDICAL QUESTIONNAIRE

YES	NO	# of members	Directions: Please check ☐ Yes or ☐ No. If any box is checked "Yes" (☒ YES) circle the condition, e.g., *STROKE*, and give details below.
☐	☐		**1.** Has anyone had a claim of $5,000 or more in the past 12 months?
☐	☐		**2.** Has anyone been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years?
			3. Has anyone been advised, diagnosed or treated by a physician in the past 5 years for:
☐	☐		**A.** Stroke, heart, circulatory, vascular disease or disorder, or high blood pressure?
☐	☐		**B.** Cancer, tumors, leukemia, lupus or any other systemic disease?
☐	☐		**C.** Multiple sclerosis, paralysis, arthritis or bone/joint/back/muscle disorders?
☐	☐		**D.** Asthma, emphysema, respiratory or lung disorders?
☐	☐		**E.** Diabetes, pancreas, growth disorder or endocrine disorder?
☐	☐		**F.** AIDS, tested positive for HIV, immune system disorders or blood disorders?
☐	☐		**G.** Hepatitis/liver disorder, digestive system disease or disorder, colon disorder, kidney/prostate/reproductive organs disorder or infertility?
☐	☐		**H.** Nervous system or brain/seizure disorder, mental/emotional disorders, alcohol/drug/substance abuse or dependency?
☐	☐		**I.** Organ transplant or bone marrow transplant?
☐	☐		**J.** Other?_____
☐	☐		**4.** Are any employees or dependents currently pregnant?

If you have answered "Yes" to any of the questions above, please provide details below. Use an additional page if needed.

DETAILS OF MEDICAL HISTORY

Question #	Name (optional)	Employee, Spouse, or Child	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery
Example is shown in gray boxes								
3A	**Spouse**	Employee, (Spouse), Child	**36**	M_X_ F____	**Stroke**	**Surgery**	**5/3/2005**	
		Employee, Spouse, Child		M____ F____				
		Employee, Spouse, Child		M____ F____				
		Employee, Spouse, Child		M____ F____				
		Employee, Spouse, Child		M____ F____				

The following information is needed to comply with Public Act 86-537, as amended, which regulates the Discontinuation and Replacement of Group Insurance policies. Each covered person will be given credit toward our participating provider program deductible for prior deductible and waiting periods satisfied under the prior carrier's coverage based on information provided to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") by the group. HCSC reserves the right to accept or, where not prohibited by law, reject the entire group based on the information provided. HCSC further reserves the right to change the quoted rates or withdraw the proposal if any of the above information changes was omitted, or has been reported inaccurately.

What is the provision in the current insurance carrier's contract for **coverage during lay off, leave of absence and disability**?

_____

What is the current carrier's **extension of benefits provision** for medical services in the event of employer group cancellation?

_____

Has the Group's **medical coverage ever been cancelled**, or applications for coverage been declined or withdrawn? ☐ Yes ☐ No

If yes, explain. _____

If additional space is needed for any of the above, please attach a separate sheet with the required information.

SECTION C

Insurance Company History (All Insurance Companies, including HMO, in the previous five years)

Insurance Company Name	Period Insured
Current:	
Previous:	

Current Carrier Premium Rates for:	Plan Type (HMO, PPO, other)	Current Policy	Renewal	Benefit Levels (Deductible and Coinsurance)
Employee	☐ HMO ☐ PPO ☐ Other (specify:)_____	$_____ $_____ $_____	$_____ $_____ $_____	Deductible: _____ Coinsurance: _____
Employee plus Spouse	☐ HMO ☐ PPO ☐ Other (specify:)_____	$_____ $_____ $_____	$_____ $_____ $_____	Deductible: _____ Coinsurance: _____
Employee plus Child(ren)	☐ HMO ☐ PPO ☐ Other (specify:)_____	$_____ $_____ $_____	$_____ $_____ $_____	Deductible: _____ Coinsurance: _____
Family	☐ HMO ☐ PPO ☐ Other (specify:)_____	$_____ $_____ $_____	$_____ $_____ $_____	Deductible: _____ Coinsurance: _____
Total Monthly Health Premium		$	$	

SECTION D

Medicare Secondary Payer (MSP) Employer Acknowledgement

Indicate below the total number eligible for Medicare in each category:

Active Employees _____ **Dependents** _____ **Retirees Under Age 65** _____ **Retirees Over Age 65** _____

As an officer of the above named Employer, I have been provided with a pamphlet entitled "Information Regarding the Medicare as Secondary Payer Statute." I understand that Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC,) will provide basic information about individuals who are both enrolled in the Employer group health insurance plans and are covered by Medicare to the Centers for Medicare and Medicare Services ("CMS") formerly known as Health Care Financing Administration ("HCFA"), which administers Medicare. The ability to make primary and secondary determinations involving such individuals and thus to assist CMS in processing MSP claims properly in the first instance depends on the breadth and accuracy of the information provided by the Employer to HCSC concerning individuals covered by our group health insurance plans. To ensure continuing accuracy, the Employer acknowledges its responsibility to notify HCSC promptly of any changes in the size of our work force or the status of employees or their dependents that might affect the order of payment under the MSP statute. Furthermore, the Employer has conducted a survey of all insured employees and retirees under age 65 and their dependents and represents that on this date, the information contained herein is correct.

I have read all the statements above and represent that they are true and complete to the best of my knowledge and belief.

_____ _____

Employer or Authorized Purchaser Signature and Title **Date**

_____ _____

Producer Signature **Date**