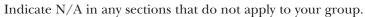
EMPLOYER GROUP INFORMATION





SECTION A										
Employer Name				— En	nlover]	Fav ID #		_	_	
Type of Business										
Parent Company Name							_		_/	
Prior Group Coverage with								ion, a N	Mutua	l Legal Reserve
Company?							-			~
Is the Group's current fund	ding arran	gement fu	ally insured? \square Yes \square	No						
What is the Group's current health coverage renewal date?/										
Number of Part-Time Employees:		_	Number of Out-of-State Resident Enrollees:				Total Number Enrolled:			
Number of Full-Time Employees:		_	List: State	Number of Employees Nur			Numbe	mber with Signed Waivers:		
Number of Total Employees:		_								
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 Fan						f Coverage ended	
								Healt	h 🗌 Dental	
							☐ Health ☐ Dental			
							☐ Health ☐ Dental			
List below the names of co facility; 4) maternity leave;								inemer	nt in a	health care
Employee Name		Age	Reason for Absence (1-9)	Plan Type (PPO, HMO, etc.)		c.) Da	Date Last Worked		Fan	nily Coverage (Y or N)
List below all disabled Spor	uses and/o	or Childre	n who are currently cov	vered by tl	he group	health pla	n.			
Spouse or Child Name	Age	E	mployee Name	Plan 7 (PPO, HM		Date of Disability				Medicare Eligible (Y or N)

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

MEDICAL OUESTIONNAIRE

	HCAL QU										
YES	NO					Yes or ☐ No. Ind give details b	f any box is check elow.	xed "Yes" (∑ YE\$	S)circle the		
		_	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?										
Question #	Name(option is shown in gra	nal) Employe Spouse,	ee,	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery		
3A	Spouse	Employee Ch		36	M_X F	Stroke	Surgery	5/3/2005			
		Employee Chi			M F						
		Employee Chi			M F						
		Employee Chi	ild		M F						
		Employee Chi			M						
Insurance periods sat Service Co reject the c any of the What is the What is the Has the Gr	policies. Each co- isfied under the rporation, a Mut entire group base above information e provision in the e current carrier'	vered person wi prior carrier's c ual Legal Reserved on the inform on changes was of e current insurants s extension of b	ill be given overage bave Compar nation proomitted, on nice carrier penefits pro	credit to sed on in ny ("HCS vided. He has bee 's contra ovision fo	oward our proposed our proposed our proposed out for cover or medical sections out the cover out of the cove	participating provious provided to Blue group. HCSC reserves the righ inaccurately. Tage during lay off services in the even	regulates the Discorder program deductors and Blue Shider pross and Blue Shider prosses the right to accept to change the quotes, leave of absence and of employer ground declined or withdraw	tible for prior deducted of Illinois, a Diversity or, where not poted rates or withdrand disability?	actible and waiting rision of Health Care prohibited by law, aw the proposal if		
If yes, expl	aiii	If additional	space is need	ed for any o	of the above, ple	ease attach a separate s	heet with the required info	ormation.			

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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:		
Employee plus Spouse	HMO PPO Other (specify:)	\$ \$ \$	\$ \$ \$	Deductible:		
Employee plus Child(ren)	HMO PPO Other (specify:)	\$ \$ \$	\$ \$ \$	Deductible: Coinsurance:		
Family	HMO PPO Other (specify:)	\$ \$ \$	\$ \$ \$	Deductible:		
Total Monthly Health Premium		\$	\$			
SECTION D						
Medicare Secondar	y Payer (MSP) Employer Acknowledgement					
Indicate below the to	tal number eligible for Medicare in each category:					
Active Employees Dependents Retirees Under Age 65 Retirees Over Age 65						
Secondary Payer State Mutual Legal Reserve health insurance plan Health Care Financir determinations involv breadth and accuracy insurance plans. To e in the size of our wor statute. Furthermore,	bove named Employer, I have been provided with a late." I understand that Blue Cross and Blue Shield to Company (HCSC,) will provide basic information as and are covered by Medicare to the Centers for I lag Administration ("HCFA"), which administers Meding such individuals and thus to assist CMS in proof of the information provided by the Employer to Fensure continuing accuracy, the Employer acknowledge for the status of employees or their dependence on the Employer has conducted a survey of all insure in this date, the information contained herein is continuing accuracy.	of Illinois, a Division about individuals we Medicare and Medicare. The ability decessing MSP claims ICSC concerning in edges its responsibilents that might affed employees and re-	on of Health Ca who are both en care Services (" to make primar properly in the adividuals cover lity to notify HO ct the order of	re Service Corporation, a arolled in the Employer group CMS") formerly known as y and secondary first instance depends on the ed by our group health CSC promptly of any changes payment under the MSP		
I have re	ad all the statements above and represent that they are	true and complete to	the best of my kn	owledge and belief.		
Employer or Authorized Po	ırchaser Signature and Title			Date		
Producer Signature				Date		

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