AUSHC Group Medical Questionnaire

Name of Prospect _____ Date Completed _____

Servicing Field Office _____ Contract State_____ Sales Consultant _____

Type of Industry _____ SIC Code _____

Plan Information

Is there a group plan currently in place? ☐Yes ☐ No

If yes, is it an Aetna US Healthcare or NYLCare plan? ☐Yes ☐No If yes, group number _____

Please identify the current carrier(s), plan type, current rates and last rate increase:

Carrier Name	Plan Type	EE $	Sgl Dep or Spouse $	Child $	Sp & Child $	Last Rate Increase %

Please identify employer contributions:
EE _____ Single Dep or Spouse _____ Child _____ Spouse & Child _____

What types of medical plan options will be available (☐check here if full replacement):

HMO___ QPOS___ IMO___ PPO___ Other___ please describe

_____

Prospective Group Information

1) Total number of eligible employees _____
2) How many are enrolled in the current plan or are likely to enroll if there is no plan today? _____
3) Participation _____%
4) How many eligible employees not on (or not expected to be on) the company sponsored plan, have spousal or individual coverage? _____
5) Current number of COBRA Continuees_____
6) What classes are eligible for coverage? ☐Full Time ☐Part Time ☐Retirees ☐Early Retirees
7) If Part time, are contributions the same as full time employees? ☐Yes ☐No
8) Do all eligible employees work 25 or more hours? ☐Yes ☐No
9) Retiree plan type if retirees are covered _____
10) How many Early Retirees are covered? _____ and % of total eligibles _____%
11) What is the average age of eligible employees? _____
12) Is the bill from the current carrier paid to date? ☐Yes ☐No

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Medical Profile

Plan sponsor: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than $25,000 been paid in the last 12 months? ☐Yes ☐No

B. Within the past 12 months, has any employee or dependent had a serious continuing claim (i.e., chronic or ongoing condition likely to cost $10,000 or more per year for treatment) due to a mental or physical disorder? ☐Yes ☐NO If "Yes," check the appropriate box(es) below.

☐AIDS/Immune Disorders	☐Cardiovascular	☐Infertility	☐Neurological
☐Alcohol Abuse	☐Diabetes	☐Intestines	☐Pancreas
☐Arthritis	☐Drug/Substance Abuse	☐Kidney	☐Skin
☐Back, Neck	☐Epilepsy	☐Liver	☐Stomach
☐Blood	☐Ears/Eyes	☐Lungs	☐Stroke/Paralysis
☐Bone/Joint	☐Emphysema/Pulmonary	☐Lupus	☐Venereal
☐Brain	☐Heart Disease	☐Mental/Nervous	☐Other, Detail below
☐Cancer/Tumor	☐High Risk Pregnancies	☐Migraines	

C. Are any employees or dependents pregnant? ☐ Yes ☐No If "Yes," how many? _____

If you answered "Yes" to question A or B, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	$ Amount of Prior Claims	Prognosis / Current Treatment

The information on this form is designed to assist in Aetna US Healthcare's evaluation of your group. The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please Print)	Prospective Applicant Signature	Date
Agent Signature (Existing ☐Yes ☐No) Date	Sales Representative Signature	Date