



I. GENERAL INFORMATION

Name of Business _____ Anniversary Date _____
 Business Address: _____ City _____ State _____ Zip Code: _____
 Nature of Business _____ S.I.C. Code _____

II. GROUP ABSTRACT

1. Number of Years in Business _____ (Attach your most recent financial statement if less than two years.)
2. Indicate Classes of Eligible Employees /Waiting Period _____
3. Rates for Group Medical:

| | <u>Current Rates</u> | <u>Renewal Rates</u> | <u>Number of Emp. Eligible</u> | <u>Number of Emp. Enrolled</u> |
|-------------------|----------------------|----------------------|------------------------------------|------------------------------------|
| Effective Date | _____ | _____ | _____ | _____ |
| Single | _____ | _____ | _____ | _____ |
| Employee & Spouse | _____ | _____ | _____ | _____ |
| Employee & Child | _____ | _____ | _____ | _____ |
| Family | _____ | _____ | _____ | _____ |
4. Employer Contribution _____% of Employee Premium; _____% of Dependent Premium.
5. Current Group Medical Insurer & Effective Date _____
 Reason for Current Bid Request _____
6. Five Year Prior Group Medical History & Effective Date _____
 Reason for Cancellation _____
7. Number of Employees/Dependents on COBRA Continuation _____ (Provide details in section IV)
8. Has your group been declined for coverage during the last 12 months [] Yes [] No If yes, provide details:

III. GROUP MEDICAL HISTORY

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). This information will be used to evaluate medical risk, not eligibility for individual coverage. The Health Insurance Portability and Accountability Act (“HIPAA”) prohibits group health insurance issuers from establishing rules for eligibility on the basis of health factors. Health factors are defined as: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, and disability.

Yes No 1. Within the past 12 months have any employees or their dependents been diagnosed or treated for any of the conditions below? Please check the appropriate box(es).

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ARC or AIDS | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune System | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Drug/Substance Abuse | <input type="checkbox"/> Infertility | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Enlarged Lymph Nodes | <input type="checkbox"/> Intestines | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Back, Neck | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Ears/Eyes | <input type="checkbox"/> Liver | <input type="checkbox"/> Stroke/Paralysis |
| <input type="checkbox"/> Bone/Joint | <input type="checkbox"/> Emphysema/Pulmonary | <input type="checkbox"/> Lungs | <input type="checkbox"/> Transplants |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Growth Disorders | <input type="checkbox"/> Lupus | <input type="checkbox"/> Vascular Disease |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental/Nervous | <input type="checkbox"/> Venereal |
| <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> High Risk Pregnancies | <input type="checkbox"/> Migraines | <input type="checkbox"/> Other, Detail Below |

Yes No 2. Within the last 12 months has any employee or their eligible dependent been hospitalized or had any surgical consultation advice or treatment for any condition?

Yes No 3. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

Yes No 4. Within the last 12 months, has any employee or their eligible dependent had medical claims in excess of \$10,000?

If you answered "Yes" to any of the medical questions, please complete the following:

| Question # | Illness and Medication | Year of Treatment | Age 18 or Younger |
|------------|------------------------|-------------------|-------------------|
| | | | |
| | | | |

IV. ADDITIONAL INFORMATION

COBRA CONTINUANCE

Provide details on type of qualifying event and expiration date of each person entitled to COBRA continuance.

The undersigned Company Officer and Agent hereby acknowledges that: 1) the information set out in this Underwriting Questionnaire will be relied on by Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc.; (2) this information is complete, truthful and correct; (3) to the best of my knowledge no information has been withheld or omitted concerning the past and present state of health of eligible employees and their dependents applying for this coverage and; (4) the summary health information set out in this Underwriting Questionnaire was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Print Name of Authorized Company Officer

Signature of Authorized Company Officer

Date

Title of Officer

Print Name of Agent/Agent Number

Signature of Agent

Date

Name of Agency