PrestigePEO℠

Group Health Questionnaire (page 1 of 7)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. The questionnaire will not be accepted if incomplete. Use additional paper if necessary.

Fields marked with an asterisk "*" are required

*Date _____ *Proposed Effective Date: _____

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
*Company Name					
*Street Address					
*City		*State		*Zip	
County		Benefits Contact & Phone #			
*Total Number of employees on payroll:		*Total Full Time: *Total Part Time:		*Total Number of employees currently enrolled in health care plan:	
*Payroll Cycle: ☐Weekly ☐Bi-Weekly ☐Semi-Monthly ☐Monthly					
*Number of Payroll Delivery Sites:		*State Unemployment Rates within each state the company currently conducts business:			
*Are any health plan enrollees NOT paid employees (other than spouses or children)? ☐Yes ☐No ***If yes, please provide names and details:					
*Current Health Carrier:		*Health Carrier Renewal Date: / /			
*Is your current Plan Self-Funded? ☐Yes ☐No ☐Don't Know ***If yes, please provide claims.					
*Are you currently with a PEO? ☐Yes ☐No *If yes, name of PEO:		*Any ineligible class of employees ☐Yes ☐No If yes, which class:			
Please provide a complete description of your business operation:				SIC Code:	

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***Number of Locations: _____**	***Please identify all states of operation: _____**
***Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company, or a PEO? ☐ Yes ☐ No** ***If yes, please briefly explain the reason why and when this occurred:**	

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A. *List any current participants in COBRA / State Continuation (use additional paper if necessary):

☐ **NONE**

Details of Individual (i.e. Name, DOB, Zip Code, Coverage Tier)	COBRA Effective Date / End Date
	/
	/
	/
	/
	/
	/
	/
	/
	/
	/

B. List any participants currently eligible for COBRA who have *not yet elected* coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date (use additional paper if necessary):

☐ **NONE**

Name	Date Eligible	Activating Event/Date

C. List any employees and/or dependents who are on the health plan that are disabled:

☐ **NONE**

Name	Disability	Qualifying Event

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II. RATE HISTORY (if more than 3 plans, include the 3 most popularly-elected plans)				
Plan 1 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 2 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

Plan 3 Name: _____	**# Enrolled: _____**	**Renewal Rates (eff.__/__/____)**	**Most recent 12 months**	**13-24 months prior**
Premium Rates				
Employee Only	#	$	$	$
Employee + Spouse	#	$	$	$
Employee + Child(ren)	#	$	$	$
Employee + Family	#	$	$	$

III. CURRENT PLAN BENEFIT SUMMARY INFORMATION (Individual, in-network only)			
Current Plan Names:	**1:**	**2:**	**3:**
Current Plan Types:	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ EPO	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Annual Deductible			
Co-Insurance (as %)			
Out-of-Pocket Max (excluding deductible)			
Office Visit Copay			
Prescription Drug Copay generic / brand formulary / brand non-formulary	/ /	/ /	/ /

IV. CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (by $ or %)				

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Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

GENERAL ILLNESS QUESTIONS:	*To the Best of My Knowledge (any or all):
a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years? b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability? c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? ***(If yes to any or all, please provide details in the table below.)***	☐YES ☐NO

SPECIFIC ILLNESS QUESTION:

*Is anyone currently being treated or been advised to seek treatment for any of the following?

*Please select all that apply:

- ❑ AIDS or testing HIV Positive
- ❑ arthritis
- ❑ back disorder
- ❑ cancer
- ❑ diabetes
- ❑ heart disease
- ❑ kidney disorder
- ❑ liver disease
- ❑ mental illness
- ❑ muscular disorder
- ❑ nervous system disorders
- ❑ respiratory disease
- ❑ stroke
- ❑ substance dependency
- ❑ transplants
- ❑ tumor
- ❑ other serious conditions

(If any boxes are selected, please provide details in the table below.)

Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

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Known Medical Conditions <u>to the best of your knowledge</u> (continued):

*IS ANYONE CURRENTLY PREGNANT? If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy. *This includes employees, dependents or COBRA participants.*	*To the Best of My Knowledge: ☐ YES ☐ NO

Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

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Client Privacy Notifications

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detail health information (protected health information) that you provide via hard copy or through the Milliman, Inc. HERO Online Data Collection Website will be used solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), association group (Association) or Trust that will provide a health insurance quote to the employer. Milliman is acting as a Business Associate to the PEO/MEWA/ Association/Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations. Milliman will not sell, license, transmit or disclose this information outside of Milliman unless: a) necessary for Milliman to provide the services on behalf of the PEO/MEWA/Association/Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

Prestige Employee Administrators, LLC ("PrestigePEO"):
I certify on behalf of the client company ("company") that the statements comprised of aggregate health information regarding the company's employees ("employees") are true and correct to the best of my knowledge. I understand that this form is used for information purposes only and does not bind coverage. I will notify PrestigePEO of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage.

In the event that material information has been omitted or is inaccurate, the insurance carrier may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, the PrestigePEO service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that PrestigePEO also may adjust the company's insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation. PrestigePEO gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

Note: Prospective employees in the state of **Michigan** should not provide information regarding height or weight.

PrestigePEO's Notice of Privacy Practices ("NOPP") provides more detailed information about how PrestigePEO and the health plan chosen on behalf of the company may use and disclose employee protected health information. Both I and the employees have a legal right to review this NOPP before I sign this consent on behalf of the company and are encouraged to read it in full. The employees have a right to request restrictions on how their protected health information is used and disclosed. PrestigePEO and the health plan are not required by law to grant such request however, if such request is granted PrestigePEO and the health plan are bound by their agreement. I, on behalf of the company, have a right to revoke this consent in writing, except to the extent PrestigePEO or the health plan have already used the disclosed protected health information in reliance upon this consent.

Information disclosed on this form is considered valid for effective dates within 90 days of date signed. I will notify PrestigePEO of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage. I understand that PrestigePEO reserves the right to re-underwrite based on a change in the Census or Demographics.

***Authorized Signature**	***Title**	***Date**
***Print Name**	***Print Name of Company**	
Broker / Sales Signature	**Broker / Sales Print Name**	**Date**