



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.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> AIDS/Immune Disorders | <input type="checkbox"/> Cardiovascular | <input type="checkbox"/> Infertility | <input type="checkbox"/> Neurological |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Intestines | <input type="checkbox"/> Pancreas |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Drug/Substance Abuse | <input type="checkbox"/> Kidney | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Back, Neck | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Blood | <input type="checkbox"/> Ears/Eyes | <input type="checkbox"/> Lungs | <input type="checkbox"/> Stroke/Paralysis |
| <input type="checkbox"/> Bone/Joint | <input type="checkbox"/> Emphysema/Pulmonary | <input type="checkbox"/> Lupus | <input type="checkbox"/> Venereal |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mental/Nervous | <input type="checkbox"/> Other, Detail below |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> High Risk Pregnancies | <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No) Date	Sales Representative Signature	Date