

GROUP INSURANCE POLICY OPTIONS

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Industry: _____ Requested Effective Date: _____

PLAN SELECTION

Do you currently have group coverage? _____ YES _____ NO

Please select the your current options you have below.

If no please select the options you would like to include on a group plan.

PPO PLANS:

Deductible	Coinsurance	Coinsurance Limit	Network
500 _____	90/70 _____	5000/15000 _____	_____
1000 _____			_____
1500 _____	80/60 _____	10000/20000 _____	_____
2000 _____			_____
3000 _____			_____

OFFICE VISITS:

20 _____ 30 _____ 40 _____ NO OFFICE VISIT _____

RX DRUG CARD RETAIL 30 DAY SUPPLY. MAIL SERVICE 90 DAY SUPPLY

Deductible Per Person: 400 _____ 200 _____ 0 _____

MATERNITY: YES _____ NO _____

HSA Select Plan:

Deductible	Coinsurance	Network
1000/2000 _____	100/80 _____	_____
1500/3000 _____	90/70 _____	_____
2000/4000 _____	80/60 _____	_____
3000/6000 _____		_____

DENTAL:

Orthodontic	Calendar Year Max
YES _____	1000 _____
NO _____	1500 _____

LIFE:

Flat Amount: _____

OPTIONS:

LTD	Benefit Level
_____	60% _____
STD _____	66.67% _____
	70% _____

PRE-APPLICATION MEDICAL QUESTIONNAIRE

Every Employee MUST Fill Out One

NAME OF GROUP:

	GENDER	HEIGHT	WEIGHT	BIRTHDATE	AGE
EMPLOYEE					
SPOUSE					
DEPENDENT					
DEPENDENT					
DEPENDENT					
DEPENDENT					

HEALTH HISTORY

Mark every one of those that apply to yourself or any other dependent enrolling in insurance at this time. Mark the condition if you have ever had or been advised to seek treatment for any of the following.

<input type="checkbox"/>	CANCER	<input type="checkbox"/>	CURRENTLY PREGNANT
<input type="checkbox"/>	LEUKEMIA	<input type="checkbox"/>	LUNG DISORDER/DISEASE
<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	PARALYSIS
<input type="checkbox"/>	KIDNEY CONDITION	<input type="checkbox"/>	LIVER CONDITION
<input type="checkbox"/>	SEIZURES OR EPILEPSY	<input type="checkbox"/>	HEART CONDITIONS OR SURGERY
<input type="checkbox"/>	TRANSPLANT SURGERY	<input type="checkbox"/>	HIGH CHOLESTEROL
<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	MENTAL OR NERVOUS CONDITION
<input type="checkbox"/>	ALCHOL OR DRUG ABUSE	<input type="checkbox"/>	BACK OR SURGERY
<input type="checkbox"/>	ARTHRITIS(specify Rheumatoid or Osteo)	<input type="checkbox"/>	STOKE

ANY OTHER MEDICAL CONDITION NOT LISTED

Please provide details on the conditions marked above, the dates of treatment or diagnosis.

List all Current medications taken by everyone enrolling in the medical insurance.

Has anyone been advised of any future treatments, if so what and when.

Has anyone enrolling in insurance at this time used any tobacco products in last 12 months	YES	NO
EMPLOYEE		
SPOUSE		
DEPENDENT		
DEPENDENT		
DEPENDENT		
DEPENDENT		