



Today's Date _____

INSURANCE REQUEST FORM

Company Name _____	Referred by: _____
Type of Business _____	C-Corp _____ Partnership _____
SIC Code _____	S-Corp _____ Sole Prop _____
Owner _____	Email _____
HR Contact _____	Email _____
Phone Number _____	Website _____
Fax Number _____	
Primary Address _____	Multi Locations? _____
City/State/Zip _____	Worker's Comp? _____
# Employees _____	Full Time# _____ Part Time# _____

Employer Contribution? *Percentage or Flat Dollar Amount:* _____
 New Hire Wait? *0/30/60/90 Days* _____
 Payroll Deductions? *12/24/26/52* _____

CURRENT COVERAGE	MEDICAL	CARRIER NAME	Rates
<i>Effective Date</i> _____	_____	_____	EO _____
Deductible _____			ES _____
Coinsurance _____			EC _____
Out of Pocket Max _____			EF _____
Office Visit Copay _____			
RX Copay _____			

CENSUS COUNT	NAME	M/F	BIRTHDATE	HM ZIP	COVERAGE (EO, ES, EC, EF,W)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

SMALL GROUP EMPLOYER MEDICAL QUESTIONNAIRE

Complete the following questions to the best of your knowledge for eligible employees, their dependents, and any COBRA participants, state continuation participants, or state dependent continuation participants. If your current carrier is BCBSTX, your response to the medical questions should be based on eligible employees and/or dependents not currently on your employee group health plan. If BCBSTX is your current carrier, provide your Group/Account Health Number:

1. How many employees or dependents have had a claim of \$5000 or more in the past 12 months? _____

2. How many employees or dependents have been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? _____

3. How many employees or dependents have been advised, diagnosed, or treated by a physician in the past 5 years for:

(Enter the number of employees or dependents with the condition and provide details on the next page.)

A. _____ Stroke
 _____ Circulatory Disease or Disorder
 _____ High Blood Pressure

_____ Heart Disease or Disorder
 _____ Vascular Disease or Disorder

B. _____ Cancer
 _____ Leukemia
 _____ Chronic Skin Condition

_____ Tumors
 _____ Lupus
 _____ Any other Systemic Disease

C. _____ Multiple Sclerosis
 _____ Osteoarthritis
 _____ Joint Disorders
 _____ Muscle Disorders

_____ Paralysis
 _____ Other Severe Arthritis
 _____ Back Disorders
 _____ Bone Disorders

D. _____ Asthma
 _____ Respiratory and Lung Disorders

_____ Emphysema

E. _____ Diabetes
 _____ Growth Disorder

_____ Pancreas
 _____ Endocrine Disorder

F. _____ AIDS
 _____ Immune System Disorders

_____ Tested Positive for HIV
 _____ Blood Disorders

G. _____ Hepatitis
 _____ Digestive System Disease or Disorder
 _____ Kidney Disorder
 _____ Reproductive Organs Disorder
 _____ Urinary Tract Disorder

_____ Liver Disorder
 _____ Colon Disorder
 _____ Prostate Disorder
 _____ Infertility

H. _____ Nervous System/Brain/Seizure Disorders
 _____ Alcohol/Drug/Substance Abuse or Dependency

_____ Mental/Emotional Disorders

I. _____ Organ Transplant

_____ Bone Marrow Transplant

J. _____ Other

4. How many employees or dependents are currently pregnant? _____

