

Employer Questionnaire – 51+ Enrolled Quotes



Please complete this Employer Questionnaire to the best of your knowledge. Once completed, Employer Questionnaires should be signed and returned to the Destiny Health and/or Guardian Underwriting Office.

1) General Group Data

Company Name: _____ Phone Number: _____
 Main Address: _____ Other locations: _____
 Name of Broker: _____ SIC / Type of Business: _____

2) Carrier History – Please provide the carrier history for the past 5 years

Carrier Name: _____ From _____ To _____
 Carrier Name: _____ From _____ To _____
 Carrier Name: _____ From _____ To _____
 Carrier Name: _____ From _____ To _____

3) Current and Renewal Rates

Effective Date: _____	Current Rates		Renewal Rates	
	PPO/POS	HMO	PPO/POS	HMO
Tier				
EE Only	_____	_____	_____	_____
EE/Sp	_____	_____	_____	_____
EE/Ch(ren)	_____	_____	_____	_____
Family	_____	_____	_____	_____

4) Current Plan Design

A copy of your current plan design(s) will be required. Please document below if the appropriate plan summaries are attached:

PPO/POS Plan Summary attached? Yes _____ No _____ HMO Plan Summary attached? Yes _____ No _____

Do the renewal rates shown above reflect any plan changes? Yes _____ No _____

If yes, please provide details: _____

5) Employer Contributions – Please provide either dollar or percentage amount of employer contributions

Tier	PPO/POS	HMO
EE Only	_____	_____
EE/Sp	_____	_____
EE/Ch(ren)	_____	_____
Family	_____	_____

6) Retiree and COBRA Enrollment

	PPO/POS	HMO
COBRA	_____	_____
Pre-65 Retirees	_____	_____
Post-65 Retirees	_____	_____

7) Number of Employees Enrolled & Waived

	PPO/POS	HMO	Total
Number of EE's Enrolled	_____	_____	_____
Number of EE's Waiving Coverage	_____	_____	_____

The following questions (8-15) should be answered for **ALL** members (including dependents and individuals on COBRA) for whom coverage is being requested.

8.	Are there any members restricted from normal activities due to disability or injury, <u>including</u> members currently confined to their home, a hospital or other treatment facility?	Yes ___	No ___
9.	Has any employee missed 10 or more consecutive days of work in the past 12 months due to sickness or injury?	Yes ___	No ___
10.	Are you aware of any dependents age 19 or older who might be considered developmentally disabled or physically handicapped?	Yes ___	No ___
11.	Are you aware of any member with claims in excess of \$10,000 in the past 12 months?	Yes ___	No ___
12.	Are you aware of any members who have the potential to incur claims in excess of \$10,000 in the 12 months following the requested effective date?	Yes ___	No ___
13.	Are you aware of any members who have been advised of the need for surgery, hospitalization, diagnostic testing or other medical treatment not yet performed?	Yes ___	No ___
14.	Has any member been treated for or diagnosed as having: AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex (ARC) or other Immune System Disorders; Blood or Bleeding Disorder; Cancer; Congenital Disorders; Connective Tissue Disorders (Lupus, Rheumatoid Arthritis, etc.); Diabetes; Heart Disease; Hypertension; Chronic Hepatitis; Kidney Disease/Kidney Failure; Liver Disease; Neurological Disorders or Brain or Spinal Cord Injuries; Organ Transplants; Respiratory Disease; Stroke; Expectation of Multiple or High Risk Birth or Any Other Serious Disease?	Yes ___	No ___
15.	Are there any employees who are to be covered who are not actively at work? (required for Life and Disability application only)	Yes ___	No ___

For each question (8-15) answered “yes”, please provide the following additional information for each member. If more space is needed, attach a separate page giving full details (you will need to sign and date each page). **Please do NOT disclose any personally identifiable information such as name or social security number.**

Qst #	Medical Condition / Diagnosis	Age & Gender	Date of diagnosis	\$ Amount of Claims	Dates & details of surgery, hospitalization or other treatment	Ongoing treatment required? Yes/No – if yes, provide details

This Employer Questionnaire is intended to help Destiny Health and/or Guardian underwrite your request for group insurance. Do not cancel your present group insurance coverage without written notice of approval from the Destiny Health and/or Guardian underwriting department. **This Employer Questionnaire must be signed by a human resource director/manager.**

Name: _____

Signature: _____

Title: _____

Date: _____

Required Information – 51+ Proposals

Data Element		Quotes w/ 51-100 EE's	Quotes w/ 100+ EE's
1)	Employer Questionnaire	Required	Required
2)	Census – including age, sex, zip, enrollment selection and plan chosen (if more than one plan design offered)	Required	Required
3)	Address(es)	Required	Required
4)	SIC / Type of Business	Required	Required
5)	Carrier History – Past 5 Years	Required	Required
6)	Current / Renewal Rates	Required	Required
7)	Employer Contributions	Required	Required
8)	Cobra/Retiree Enrollment	Required	Required
9)	Plan Design(s) – Including details of any plan changes made in conjunction with the current renewal	Required	Required
10)	Claim Experience – Minimum of 12 Months – Preferably on a monthly basis	Required if self-funded or carrier known to release such data	Required
11)	Employee and Member enrollment to coincide with experience provided – preferably on a monthly basis	Required if self-funded or carrier known to release such data	Required
12)	Source High Claimant Data – meaning a high claimant report from current carrier to include \$ amounts and diagnosis/prognosis info	Required if self-funded or carrier known to release such data	Required
13)	Plan Change Details – If claim experience is provided, we need details of any plan changes made in the experience period(s)	Required if self-funded or carrier known to release such data	Required