



## EMPLOYER RISK ASSESSMENT FORM

### 1.) ABOUT YOUR GROUP:

Group Name				Federal Tax ID	
Address		City	County		State
					Zip Code
SIC Code	Nature of Business			Years in Business	Phone Number
Has this group ever been known by another name? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, what names(s)?					
Has this group ever requested a proposal from Medical Mutual before? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, when?					
Is this group affiliated with other companies or unions (parent, subsidiary, joint venture, etc)? <input type="checkbox"/> NO <input type="checkbox"/> YES If yes, describe.					

**2.) EMPLOYER PREMIUM CONTRIBUTION LEVEL:** Per Employee: \_\_\_\_\_ Dependents: \_\_\_\_\_

### 3.) MEDICAL PLANS OFFERED DURING THE LAST 5 YEARS:

Carrier Name	Type of Plan *	Funding **	Effective Date	Cancel Date	Reason for Leaving

\* HMO, PPO, POS, Traditional, etc.

\*\* Fully Insured (FI) or Self-Funded (SF)

### 4.) RATE HISTORY:

	Prior Year Rates	Current Rates	Renewal Rates
Single			
Employee + Spouse			
Employee + Child(ren)			
Family			

**5.) COBRA:** Are there currently any members who are COBRA eligible or enrolled?  NO  YES (please list)

Name	SSN	Date of Qualifying Event	Expiration Date	Qualifying Event

**6.) RETIREES:** Are there currently any retirees who meet the eligibility requirements?  NO  YES (please list)

Name	SSN	Age at Retirement	Date of Retirement	Date of Hire

### 7.) ENROLLMENT:

	Active	COBRA	Retired
Current Active Employees (FT + PT) *	A.)		
Ineligible Employees (PT + 1099)	B.)		
Total Eligible (A. - B.)	C.)		
Waivers (Life Only & Total Waivers)	D.)		
COBRA Enrolled & Retirees		Ei.)	Eii.)
Total Applying (C. - D. + Ei. + Eii.)	F.)		

\* Includes owners, officers, and partners who receive compensation from the company which is reported on a tax form other than a 1099.

**8.) MEDICAL INFORMATION:**

- A.) Are any employees or dependents currently scheduled for surgery or hospitalization?  NO  YES  
 If yes, please describe: \_\_\_\_\_
- B.) Have any employees or dependents been hospitalized in the last 24 mos?  NO  YES  
 If yes, please describe: \_\_\_\_\_
- C.) Have any employees or dependents incurred claims in excess of \$10,000 in the last 18 mos?  NO  YES  
 If yes, please describe: \_\_\_\_\_
- D.) Are any employees currently on disability?  NO  YES  
 If yes, please describe: \_\_\_\_\_
- E.) Please indicate the **number** of employees or dependents who have been, currently are, or anticipate being treated for the following conditions. Please provide dates.

<input type="checkbox"/>	AIDS, ARC, HIV+	<input type="checkbox"/>	Hemophilia		
<input type="checkbox"/>	Alcohol or Drug Abuse (within 5 Years)	<input type="checkbox"/>	Kidney Dialysis / Renal Failure		
<input type="checkbox"/>	Alzheimer's	<input type="checkbox"/>	Liver (Cirrhosis)		
<input type="checkbox"/>	Aneurysm Type: _____	<input type="checkbox"/>	Liver (Hepatitis, Non-Alcoholic)		
<input type="checkbox"/>	Arthritis (Rheumatoid)	<input type="checkbox"/>	Lupus		
<input type="checkbox"/>	Attempted Suicide (within 5 Years)	<input type="checkbox"/>	Lyme's Parasitic Disease		
<input type="checkbox"/>	Back/Spine Injuries Type: _____	<input type="checkbox"/>	Lymphoma / Leukemia		
<input type="checkbox"/>	Cancer Treated < 12 Months Type: _____	<input type="checkbox"/>	Mental or Emotional Disorders Type: _____		
<input type="checkbox"/>	Cancer Treated 1- 2 Years Type: _____	<input type="checkbox"/>	Multiple Sclerosis		
<input type="checkbox"/>	Cancer Treated 3 - 5 Years Type: _____	<input type="checkbox"/>	Muscular Dystrophy		
<input type="checkbox"/>	Cancer Treated 6 - 10 Years Type: _____	<input type="checkbox"/>	Myasthenia Gravis		
<input type="checkbox"/>	Cancer Treated > 10 Years Type: _____	<input type="checkbox"/>	Paralysis		
<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	Pericarditis		
<input type="checkbox"/>	Coronary Artery Disease (within 5 Years)	<input type="checkbox"/>	Pregnancy Due Date: _____		
<input type="checkbox"/>	Coronary Bypass	<input type="checkbox"/>	Spina Bifida		
<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	Stroke (within 5 Years)		
<input type="checkbox"/>	Cystic Fibrosis	<input type="checkbox"/>	Transplant, Bone Marrow	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Diabetes (Dietary Controlled)	<input type="checkbox"/>	Transplant, Heart	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Diabetes (Oral Medication)	<input type="checkbox"/>	Transplant, Kidney	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Diabetes (Insulin)	<input type="checkbox"/>	Transplant, Liver	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Transplant, Lung	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Transplant, Pancreas	<input type="checkbox"/> Pending	<input type="checkbox"/> Received
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Ulcerative Colitis		

- F.) Did current Carrier provide a listing of high claimants?  Yes (please attach copy) No

- G.) If there is any additional information, either pertaining to conditions indicated above or others, that would be helpful to us in assessing the medical risk of your group, please describe below or attach additional pages.
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**9.) SIGNATURE:** I certify that I understand the contents of this form and that the information stated within is true and correct to the best of my knowledge and that I will promptly notify Consumers Life of any changes. Any deliberate omission or misstatement relating to answers or statements on this form can result in the denial of a claim or the rescission of coverage for the group or any group member. I understand that this form is used by Consumers Life to evaluate my group as part of the proposal process and that this is not an application for insurance.

Print Name and Title	Broker
Signature	Date
Consumers Life Representative	Date

**WARNING:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)