



Underwriting Request Form

Please complete and submit this underwriting request form for all employers with 51-100 eligible employees. Information supplied on this form should be true, accurate and complete to the best of the employer's knowledge.

CBIA Health Connections will use this information to determine whether to provide the coverage applied for, and may request additional information to make this determination. Misrepresentation of the information reported below will result in **CBIA Health Connections** retroactively rescinding any coverage granted.

Prospect Name: _____

Address (City, State, ZIP): _____

SIC Code: _____ Nature of Business: _____

Broker Name & Agency: _____

Requested Effective Date: _____

THE FOLLOWING INFORMATION MUST BE ATTACHED TO THE QUOTE REQUEST FORM:

- Copy of last months medical bill
- Census of total eligible group (including waivers)
- Copy of proposed renewal rates
- Description of current plan design
- Copy of claim experience information (A requirement for self-funded plans)

PART I: GENERAL INFORMATION

- Total number of eligible employees _____ (including waivers)
Definition of an eligible employee: full-time employee working a regular schedule of at least 30 hrs. per week. Eligible employees include employees who are compensated by 1099, COBRA continuants or retirees.
- Total number of participating employees _____
- # of COBRA continuants _____
- # of retirees (pre-65) _____ (post-65) _____
- What is the current employer contribution level? Emp _____% Dep _____%
- Has the prospect's eligible employee population remained relatively stable (no change of greater than 30% of eligible employee population in the last 12 month time period or anticipated in the future 12 month time period)? Yes No
- Have you previously requested or obtained a **CBIA Health Connections** quote? Yes No
If "Yes" please explain: _____

PART II: CARRIER HISTORY

- Current Carrier(s) _____ # of years: _____ Renewal Date: _____
Current Coverages: Indemnity _____ PPO _____ POS _____ HMO _____
Current Rates: Single \$ _____ EE/Spouse \$ _____ EE/Child(ren) \$ _____ Family \$ _____
Renewal Rates: Single \$ _____ EE/Spouse \$ _____ EE/Child(ren) \$ _____ Family \$ _____
- If two carriers or plans are currently being offered, please indicate:
of employees participating with carrier/plan #1 _____ carrier/plan #2 _____

PART III: MEDICAL HISTORY

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). Details to questions answered "Yes" should be provided below for each individual. Provide as much information as possible within your knowledge to expedite processing of underwriting. Please attach a separate sheet with details if more space is necessary.

1. Have any claims over \$10,000 been paid in the past twelve months? Yes No
2. Has any employee missed 10 or more consecutive days of work in the past 12 months due to illness or injury? Yes No
3. Are there any ongoing disabilities? Yes No
4. To the best of your knowledge, is hospitalization, surgery or treatment pending or recommended for any employees or dependents? Yes No
5. To the best of your knowledge, have any employees or dependents been diagnosed with, or received treatment for, any of the following conditions (In the past three years)? Yes No
 - Alcohol/Drug Abuse
 - Arthritis
 - Cancer (include type of cancer)
 - Diabetes (indicate if insulin dependent)
 - Heart Conditions
 - Immune System Disorders
 - Kidney Ailments
 - Liver Diseases
 - Lung Conditions
 - Obesity (Greater than 200% of ideal body weight)
 - Organ Transplants
 - Other (please provide details below)

Please also indicate whether any of these individuals are currently on COBRA, and when their COBRA eligibility will end.

Employee/ Dependent	Age	Diagnosis (include mo./yr.)	Prognosis	Last date of treatment	Other relevant information
Individual #1					
Individual #2					
Individual #3					
Individual #4					
Individual #5					
Individual #6					
Individual #7					
Individual #8					

We the undersigned, attest that the information contained herein is accurate to the best of our knowledge.

Signatures	Employer's Name & Title (Print Clearly)	
	Employer's Signature	Date
	Agent's Name (Print Clearly)	
	Agent's Signature	Date