Anthem Blue Cross and Blue Shield
EMPLOYER QUESTIONNAIRE- OHIO

Name of Employer		Business Telephone	Federal Tax ID No	Years in Business
Address	City	County	State	Zip Code
Type of Business		Name of any affiliate companies/subsidiaries?		Email Address

1. Describe all medical plans offered during the last five years:

Carrier name	Type of coverage (PPO, HMO, Indemnity, deductibles/copays)	Period in effect
1.		
2.		
3.		

2. **Please furnish a copy of your last billing statement and current benefit summary, along with this form.**

3. Please provide the following information regarding eligibility and participation:

Total number of full-time employees: _______________ Hours per week to be full-time: ___________ hours.
Total number of eligible full-time employees: _______________
Total number of employees currently enrolled in the medical plan: _______________

4. Employer contribution level: Single coverage: ____________________________ Dependent coverage: _____________________

5. Are there any members participating in the medical plan who have incurred medical expenses in excess of $10,000 in the last 18 months?

Name	Employee, Spouse or Dep.	Diagnosis	Claim Amt.	Status
1				
2				
3				

6. COBRA: Is anyone currently eligible or enrolled in COBRA? If yes, please list below:

Name	Date of Qualifying Event	Expiration Date	Qualifying Event
1			
2			
3			
4			
5			

7. Retirees: Is anyone currently enrolled in the plan as a retiree? If yes, please list below:

Name	Age at retirement	Date of Retirement	% of Employer Contribution

8. Have any employees been absent from work for 5 or more consecutive days due to illness or injury in the last 12 months?

Name	Period of time absent	Reason

9. Please provide the rate history for your group and renewal rates, if known:

	Prior Year Rates	Current Rates	Renewal Rates
Single			
Employee & Spouse			
Employee & Child			
Family			

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Medical Information

1. Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance (including dependents). Please provide details on a separate sheet of paper.

A. Has anyone been treated for a serious illness, been hospitalized or had surgery during the past 12 months? ☐ Yes ☐ No

B. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No

C. Are there any employees who, because of illness or injury, are not actively at work performing their normal duties on a full-time basis? ☐ Yes ☐ No

D. Are there any spouses or dependents who, because of illness or injury, are not either actively at work or not performing age appropriate activities of daily living? ☐ Yes ☐ No

2 Complete the following for any known medical conditions in your group:

☐ AIDS, HIV+
☐ Alzheimer's
☐ Aneurysm Type:_________________________
☐ Rheumatoid Arthritis
☐ Back/Spine Injuries Type:_______________________
☐ Cancer Present (within 12 mos) Type:_________________
  ☐ Recovered 1-2 yrs. Type: ________________
  ☐ Recovered 3-5 yrs. Type: ________________
  ☐ Recovered 6-10 yrs. Type: _______________
  ☐ Recovered 10+ yrs.
☐ Cerebral Palsy
☐ Circulatory: Coronary Artery Disease (within 5 yrs)
☐ Circulatory: Heart Attack
  ☐ Operated ☐ Unoperated
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Diabetes
  ☐ Diet Controlled
  ☐ Insulin - Adult onset
  ☐ Insulin - Child onset
  ☐ Oral Medications
☐ Emphysema
☐ Epilepsy

☐ Hemophilia
☐ Kidney Dialysis/Renal Failure
☐ Liver (Cirrhosis)
☐ Liver (Hepatitis non-alcoholic)
☐ Lupus/Connective Tissue Disease
☐ Lyme's/Parasitic Disease
☐ Lymphoma/Leukemia
☐ Mental Health Disorder ___________________________________
  ☐ Schizophrenic Disorders
  ☐ Anxiety Disorders ☐ Depressive Disorders
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Pancreatitis
☐ Paralysis
☐ Pregnancy (provide due date) ______________________________
☐ Spina Bifida
☐ Stroke (within 5 yrs.)
☐ Substance Abuse (within 5 yrs.)
☐ Transplant
  ☐ Type & Date: ____
☐ Ulcerative Colitis
☐ Other (list below)
  ☐ ____
  ☐ ____

3. Is there any additional information that you think will assist Anthem in assessing the medical condition(s) present in your group? If so, please provide in the space below:

____

____

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The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. Any person who, with the intent to defraud or knowing that he or she 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.

Employer Representative	Date
Printed Name and Title	Signature
Sales Representative	Broker Signature