MEDICAL MUTUAL™

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? ☐ NO ☐ YES If yes, what names(s)?

Has this group ever requested a proposal from Medical Mutual before? ☐ NO ☐ YES If yes, when?

Is this group affiliated with other companies or unions (parent, subsidiary, joint venture, etc)? ☐ NO ☐ 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.

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