HealthSpectrum®
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Coral Gables, Florida 33134
(305) 648-2004
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National: 1-800-586-3685

Email: info@healthspectrum.net

If your employer group consists of 51 or more employees:

In order to provide you with accurate pricing, we need some basic information regarding your company, as well as your employee census.

The information we need is as follows:
1. General Information: Your company name; address; telephone number; fax number; the nature of your business; and the name of a contact person within your organization.
2. Existing Plan Information: The proposed effective date for the new plan (quote), the name of your current insurer (if any) and, if possible, the current and renewal rates from your current insurer.
3. Employee Census: The sex, date of birth (or age), and desired coverage for each full-time employee in your organization. The desired coverage is broken down as follows: **EE** - Employee Only; **ES** - Employee + Spouse; **EC** - Employee + Child(ren); **F** - Employee + Family; & **W** - Waiving,

We will also need some information regarding your group's plan design and your group's general medical history. Please complete the Underwriting Questionnaire. Please be sure not to disclose any names as you answer the questions. By providing us with this additional information, we in turn will be able to provide you with more accurate and detailed health plan pricing.

You can e-mail the requested information to Michael Monte at mmonte@healthspectrum.net or fax it to 305-648-2005.

If you have any questions during this process, please feel free to contact us. You can either send us an e-mail or call us at 1-800-586-3685.

Thank you for giving us the opportunity to be of service to you.

HealthSpectrum, Inc.
www.healthspectrum.net

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General Information Questionnaire

Group Name:	
Address:	
City:	
State:	
Zip:	
# Years in Business:	
Nature of Business:	

Contact Person:	
Email:	
Phone:	
Fax:	

Please provide us with a current summary of benefits (if available) for the plans you have in place. If not please describe the plans in the space provided below (ie. office visit co-pays, hospital co-pays, Rx co-pays...).

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Underwriting Questionnaire-Supplement to Group Enrollment Form and Request for Plan

Group Name:________________________________
Aniversary Date:____________________
Agent Name:________________________________
Agent Phone #:____________________

Group Specific Information:

1. Current Rates: Employee:__________ Renewal: Employee:__________
   Emp/Sp: __________ Emp/Sp: __________
   Emp/Chd: __________ Emp/Chd: __________
   Family: __________ Family: __________
2. Current Plan Design:______________________________
3. Type of coverage desired (HMO, PPO, POS, Self-Funded...):________________
4. Does group have Section 125, Cafeteria Plan in Place:________________
5. Reason requesting quotation:______________________________
6. Has group been declined coverage during the last 12 months?________________

Medical Information:

When completing the questions below please be sure **NOT** to disclose the name of any employee or dependent of an employee. Be sure to answer these questions to the best of your knowledge for all employees currently covered through your current plan or under COBRA. For all yes answers please be sure to give as much detail as possible.

1. To the best of your knowledge, does any employee or covered dependent suffer from any chronic medical condition, e.g. cancer, diabetes, heart failure, substance abuse, mental illness, etc.? Yes ☐ No☐
2. Is any employee or dependent currently undergoing medical treatment or with a history of frequent medical treatment? Yes ☐ No☐
3. Is any employee or dependent of an employee currently pregnant? If so, please indicate the anticipated due date and if normal delivery or c-section is expected.
   Yes ☐ No☐

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4. Is any employee applying for coverage currently disabled or has a mental or physical disorder? Yes☐ No ☐

5. Has any employee or dependent of any employee been diagnosed as HIV positive or having AIDS, AIDS related complex or immune disorder? Yes ☐ No ☐

6. Has any employee been absent for 10 or more consecutive days in the past 12 months due to accident or injury? Yes ☐ No☐

7. Is any employee currently in the hospital or not actively at work? Yes ☐ No ☐

8. Does any employee have a developmentally disabled or physically handicapped dependent child age 19 and over? Yes☐ No ☐

9. Are you aware of any claims over $5,000 in the last 12 months on any employee or dependent? Yes ☐ No ☐ If answered yes, please provide an estimate of the amount paid and indicate the medical condition and prognosis.

Current COBRA participants:

Employee Name:	Nature of Qualifying Event:	Expiration Date:

By signing below, I hereby certify that I am the authorized company representative and that the above information is complete and true to the best of my knowledge. I understand that any group coverage will not be effective until I receive written notification. My current plan will remain in force until such time as I receive formal notification of acceptance.

Signature of Authorized Company Representative

Date

Print Name / Title

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