BlueCross BlueShield of Florida
Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

UNDERWRITING QUESTIONNAIRE
SUPPLEMENT TO GROUP APPLICATION FOR GROUPS WITH 51 OR MORE EMPLOYEES

I. GENERAL INFORMATION

Name of Business ______________________________ Anniversary Date ___________

Nature of Business ______________________________ S.I.C. Code ______________

II. GROUP ABSTRACT

1. Number of Years in Business ________ (Attach your most recent financial statement if less than two years.)
2. Indicate Classes of Eligible Employees ______________________________
3. Rates for Group Medical:

	Current Rates	Renewal Rates	Number of Emp. Eligible	Number of Emp. Enrolled
Effective Date	________	________	________	________
Single	________	________	________	________
Employee & Spouse	________	________	________	________
Employee & Child	________	________	________	________
Family	________	________	________	________

4. Employer Contribution ____________% of Employee Premium; ____________% of Dependent Premium.
5. Current Group Medical Insurer & Effective Date ______________________________

   Reason for Current Bid Request ______________________________
6. Prior Group Medical Insurer & Effective Date ______________________________

   Reason for Cancellation ______________________________
7. Number of Employees/Dependents on COBRA Continuation __________ (Provide details in section IV)
8. Has your group been declined for coverage during the last 12 months [ ] Yes [ ] No If yes, provide details:

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III. GROUP MEDICAL HISTORY

Please 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). This information will be used to evaluate medical risk, not eligibility for individual coverage. The Health Insurance Portability and Accountability Act ("HIPAA") prohibits group health insurance issuers from establishing rules for eligibility on the basis of health factors. Health factors are defined as: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, and disability.

☐ Yes ☐ No 1. Within the past 12 months have any employees or their dependents been diagnosed or treated for any of the conditions below? Please check the appropriate box(es).

☐ ARC or AIDS	☐ Diabetes	☐ Immune System	☐ Neurological
☐ Alcohol Abuse	☐ Drug/Substance Abuse	☐ Infertility	☐ Pancreas
☐ Arthritis	☐ Enlarged Lymph Nodes	☐ Intestines	☐ Skin
☐ Back, Neck	☐ Epilepsy	☐ Kidney	☐ Stomach
☐ Blood	☐ Ears/Eyes	☐ Liver	☐ Stroke/Paralysis
☐ Bone/Joint	☐ Emphysema/Pulmonary	☐ Lungs	☐ Transplants
☐ Brain	☐ Growth Disorders	☐ Lupus	☐ Vascular Disease
☐ Cancer/Tumor	☐ Heart Disease	☐ Mental/Nervous	☐ Venereal
☐ Cardiovascular	☐ High Risk Pregnancies	☐ Migraines	☐ Other, Detail Below

☐ Yes ☐ No 2. Within the last 12 months has any employee or their eligible dependent been hospitalized or had any surgical consultation advice or treatment for any condition?

☐ Yes ☐ No 3. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

☐ Yes ☐ No 4. Within the last 12 months, has any employee or their eligible dependent had medical claims in excess of $10,000?

If you answered "Yes" to any of the medical questions, please complete the following:

Question #	Illness and Medication	Year Of Treatment

IV. ADDITIONAL INFORMATION

COBRA CONTINUANCE

Provide details on type of qualifying event and expiration date of each person entitled to COBRA continuance.

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The undersigned Company Officer hereby acknowledges that: 1) the information set out in this Underwriting Questionnaire will be relied on by Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc.; (2) this information is complete, truthful and correct; (3) to the best of my knowledge no information has been withheld or omitted concerning the past and present state of health of eligible employees and their dependents applying for this coverage and; (4) the summary health information set out in this Underwriting Questionnaire was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Print Name of Authorized Company Officer	Signature of Authorized Company Officer
Date	Title of Officer