

**GROUP SCREENING QUESTIONNAIRE  
 (For District of Columbia Groups  
 with 51+ Employees)**

Check one or both companies for which application is being sought:     CareFirst BlueCross BlueShield     CareFirst BlueChoice, Inc.

**A. Company Identification:**

Name of Company: \_\_\_\_\_ Phone: \_\_\_\_\_ Date: \_\_\_\_\_

Location: \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Type of Business: \_\_\_\_\_ SIC Code: \_\_\_\_\_

**B. Health Risk Assessment:**

1. To the best of your information and belief, indicate beside each condition the total number of eligible persons\* to be covered who have been treated, are currently being treated or are expected to be treated for a condition or serious illness, such as, but not limited to:

- |   |  |
|---|--|
| ___ AIDS; HIV+ (Positive HIV Test);                       | ___ Lung Disorders, COPD, or Asthma;                     |
| ___ Cancer;   | ___ Psychiatric Disorders;                               |
| ___ Central Nervous System Disease or Multiple Sclerosis; | ___ Congenital (Birth) Defects or Disorders;             |
| ___ Chronic Heart, Kidney, or Liver Disease;              | ___ Substance Abuse;                                     |
| ___ Diabetes;   | ___ Other (List): <u>Number</u> <u>Condition/Illness</u> |
| ___ Existing Pregnancy Only;                              | _____  |
| ___ Hemophilia or Blood Disorders;                        | _____  |

2. To the best of your information and belief, is there any eligible person who has incurred \$10,000 or more in medical expenses over the past 12 calendar months, or who is expected to incur \$10,000 or more in medical expenses over the next 12 calendar months?                      **Yes**    **No**

If YES, please provide a brief description of the diagnosis and treatment for each individual:

\_\_\_\_\_

\_\_\_\_\_

**C. Current Coverage Information:**

Current Carrier:		Individual	Individual & Child(ren)	Individual and Adult	Family	Employer Contribution	Type of Benefit Plan	Estimated No. of Contracts
<b>Benefit 1</b>	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
<b>Benefit 2</b>	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
<b>Benefit 3</b>	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							
<b>Benefit 4</b>	Current Rates						<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Point of Service <input type="checkbox"/> Indemnity	
	Renewal Rates							

\*Eligible persons include owners, partners, and full-time employees; COBRA Extendees (former employees covered by your present health care carrier pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985); and the eligible family members, if any. 1099 Recipients are not eligible. Seasonal employees are not eligible. Full-time employees are defined as those who work on average at least thirty (30) hours per week.

**PLEASE COMPLETE AND SIGN THE BACK OF THIS QUESTIONNAIRE**

**C. Current Coverage Information (continued):**

<b>Projected Enrollment</b>					
Number of full-time Employees actively at work:					
Number of Employees enrolling in Spousal Coverage / Parental Coverage / Military Coverage:					
Number of Employees opting out of coverage:					
Number of COBRA Extendees:					
Will Part-Time Employees (17.5 hrs/wk) be covered?	<table border="0"> <tr> <td><b>Yes</b></td> <td><b>No</b></td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>	<b>Yes</b>	<b>No</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Yes</b>	<b>No</b>				
<input type="checkbox"/>	<input type="checkbox"/>				
If covering, number of Part-Time Employees:					
Number of Disabled former Employees:					
Number of Retirees:					

**D. Prior Coverage Information:**

- Has the Company's coverage with CareFirst and/or CareFirst BlueChoice, Inc. been cancelled within the last 18 calendar months? If so, please list the prior Group Number: \_\_\_\_\_. Any outstanding balances owed by the Company to CareFirst and/or CareFirst BlueChoice, Inc. must be reconciled before the Company will be approved for group coverage.
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
  - What is the number of carriers that the Company has had coverage with in the past five (5) years?
  - Has the Company's coverage been cancelled (or is it in the process of being cancelled) by the Company's present health care carrier?
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
  - Has the company filed for bankruptcy (or is in the process of filing for bankruptcy) within the last three (3) years? If yes, to 3 or 4 please explain:
 

<b>Yes</b>	<b>No</b>
<input type="checkbox"/>	<input type="checkbox"/>
- 
- 

**E. Review and Signature:**

It is hereby understood and agreed that:  
 The information provided herein is complete and correct to the best of my information and belief.

**WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.**

Please check your role for the Group:
  Group Administrator/Representative  
 Broker

_____	_____
Signature	Printed Name
_____	_____
Title	Date

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. are independent licensees of the Blue Cross and Blue Shield Association. © Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.