

# Employer Risk Appraisal for Groups 1-50 Eligible Employees

1. This questionnaire is designed to provide information specific to your group.
2. The information will be used in evaluating the risk characteristics of your group to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.
3. Please answer all questions to the best of your knowledge.
4. Groups of 1-24 applying for coverage, please complete sections 1, 2, 3 and sign Section 5.
5. Groups of 25-50 applying for coverage, please complete sections 1, 2, 3, 4 and sign Section 5.

EMPLOYER'S TAX IDENTIFICATION NUMBER

BROKER NAME

**PLEASE PRINT. DO NOT WRITE IN SHADED AREAS. COMPLETE BOTH SIDES, IN INK.**

## 1. BUSINESS PROFILE

|  |            |  |  |                           |   |             |
|--|------------|--|--|---------------------------|---|-------------|
| BUSINESS NAME  |            | TELEPHONE NUMBER                               |  |                           |   |             |
| BUSINESS ADDRESS (MUST BE A PHYSICAL STREET ADDRESS)   |            | CITY   | COUNTY   | STATE                     | ZIP   | COUNTY CODE |
| BUSINESS HEADQUARTERS (CITY, COUNTY, STATE)  |            | OTHER BUSINESS LOCATIONS (CITY, COUNTY, STATE) |  | CONTACT NAME AND POSITION |   |             |
| TYPE OF BUSINESS   | NAICS CODE | YEARS OF OPERATION                             | Small Employer as defined by North Carolina Statutes (NCGS 58-50-110[22])? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>A small employer has 50 or less eligible full-time employees. |                           |   |             |
| What type of ownership is this business entity? <input type="checkbox"/> Proprietorship <input type="checkbox"/> Self-Employed <input type="checkbox"/> Partnership <input type="checkbox"/> Statutory 1099 Employee <input type="checkbox"/> Limited Liability Corporation <input type="checkbox"/> Church/Nonprofit <input type="checkbox"/> Corporation <input type="checkbox"/> Other: _____ |            |  |  |                           |   |             |
| Ever filed for bankruptcy or in the process of filing? <input type="checkbox"/> Yes <input type="checkbox"/> No  |            | INDICATE CHAPTER FILED                         | Has the Bankruptcy Court approved reorganization? <input type="checkbox"/> Yes <input type="checkbox"/> No   |                           | Please provide documentation of approval to reorganize. |             |

## 2. GROUP ELIGIBILITY PROFILE

This information will be compared to actual enrollment, if your group does enroll. A difference between the enrollment information in the "Group Eligibility Profile" shown here and actual enrollment may invalidate the proposed rates.

- Total number of part-time and full-time employees, including full time employees, who will be eligible upon completion of their probationary period..... \_\_\_\_\_
- Total number of full-time employees eligible for health coverage, including employees who will be eligible upon completion of their probationary period..... \_\_\_\_\_

**The group certifies that all individuals enrolling for coverage meet the following definition of eligible employee:**

An "eligible employee" means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis. An individual who is an "employee" as that term is defined under Internal Revenue Code Section 3121 (d) (3) and works on a full-time basis for the group may be considered eligible for coverage; documentation of such "employee" status is required. For groups defined as Small Employer groups, persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible.

- Are more of the eligible employees employed in the State of North Carolina than any other one state?  Yes  No
- Total number of eligible employees applying for health coverage ..... \_\_\_\_\_
- Total number of eligible employees applying for dental coverage ..... \_\_\_\_\_
- Total number of eligible employees who are not applying that have other group coverage ..... \_\_\_\_\_
- Total number of former employees or their dependents continuing coverage through COBRA or state continuation provisions ..... \_\_\_\_\_

Please provide the following information:

| NAME OF PARTICIPANT | EMP. OR DEP.             | AGE   | NATURE OF QUALIFYING EVENT | DATE OF QUALIFYING EVENT | MONTHS REMAINING |
|---------------------|--------------------------|-------|----------------------------|--------------------------|------------------|
| _____               | <input type="checkbox"/> | _____ | _____                      | _____                    | _____            |
| _____               | <input type="checkbox"/> | _____ | _____                      | _____                    | _____            |
| _____               | <input type="checkbox"/> | _____ | _____                      | _____                    | _____            |

- Will all employees and their dependents enrolling for health coverage be required to enroll for dental coverage? .....  Yes  No  Not applying for Dental Coverage
  - Are all full-time eligible employees (excluding the owner(s) ) covered by workers' compensation? .....  Yes  No
  - Please indicate the probationary period requested for new employees .....  0  30  60  90
  - Is coverage being offered to all full-time employees? .....  Yes  No
- If no, please provide an explanation: \_\_\_\_\_
- Is this entity a Professional Employer Organization (PEO)? .....  Yes  No
  - Is your business currently enrolled in a Professional Employer Organization with leased employees? .....  Yes  No

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n. Do any full-time employees reside outside of North Carolina? (see 2b for definition of full-time employee) .....  Yes  No

Please provide the following information:

STATE OF RESIDENCE

NUMBER EMPLOYED

STATE OF RESIDENCE

NUMBER EMPLOYED

o. Are there any other employer sponsored health plans which will be in force concurrently (other employer sponsored health plans do not include dental, life or disability plans)? .....  Yes  No

Please provide the following information:

CARRIER

TYPE OF BENEFITS

NUMBER ENROLLED

% EMPLOYER CONTRIBUTION

### 3. CURRENT CARRIER PROFILE

a. Please provide a five year history of group health insurance carriers, including your current carrier:

| CARRIER NAME(S) | START DATE | PERIOD(S) INSURED | END DATE | REASON FOR TRANSFER |
|-----------------|------------|-------------------|----------|---------------------|
|                 |            |                   |          |                     |
|                 |            |                   |          |                     |
|                 |            |                   |          |                     |
|                 |            |                   |          |                     |

b. Please provide your current and renewal health rates, including any prescription drug riders:

| CARRIER NAME(S)              | NUMBER OF SUBSCRIBERS | CURRENT HEALTH RATES | RENEWAL HEALTH RATES |
|------------------------------|-----------------------|----------------------|----------------------|
| Employee Only .....          |                       |                      |                      |
| Employee + 1 .....           |                       |                      |                      |
| Employee + 2 or more .....   |                       |                      |                      |
| Employee and Child(ren)..... |                       |                      |                      |
| Employee and Spouse .....    |                       |                      |                      |
| Employee and Family.....     |                       |                      |                      |

c. What is the employer's contribution to the cost of the health program?  
(minimum contribution is 50%)

Employee coverage \_\_\_\_\_%      Dependent coverage \_\_\_\_\_%

d. What is the employer's contribution to the dental program?

Employee coverage \_\_\_\_\_%      Dependent coverage \_\_\_\_\_%

e. Please attach a copy of these forms to complete the appraisal:

- Current health carrier's latest billing statement and a description of benefits.
- Current employee census, showing age or date of birth, split by business location.
- Current health and dental carrier's latest renewal letter.
- Dental carrier's latest billing statement.

f. Will employees and their dependents be subject to a dental waiting period? **If yes**, please select dental waiting period option below:

- Applies to All
- Waived for Initial & Subsequent Timely enrollees, applies to Late enrollees (proof of prior coverage is required)

### 4. HEALTH INFORMATION PROFILE

Please provide the answers to the following questions to the best of your knowledge as they pertain to all eligible employees and/or covered dependents. It is important that you include information pertaining to those members continuing through COBRA or state continuation programs.

a. Has any person to be covered had any of the following conditions?

| CONDITION                         | YES                      | NO                       | CONDITION                                | YES                      | NO                       | CONDITION  | YES                      | NO                       |
|-----------------------------------|--------------------------|--------------------------|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Heart disease .....               | <input type="checkbox"/> | <input type="checkbox"/> | Seizures.....                            | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, Tumors.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| High blood pressure .....         | <input type="checkbox"/> | <input type="checkbox"/> | Back disorders .....                     | <input type="checkbox"/> | <input type="checkbox"/> | Liver disorder .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Stroke.....                       | <input type="checkbox"/> | <input type="checkbox"/> | Chronic lung disorders.....              | <input type="checkbox"/> | <input type="checkbox"/> | Multiple Sclerosis.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes or high blood sugar..... | <input type="checkbox"/> | <input type="checkbox"/> | Muscular Dystrophy .....                 | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Nervous System disorder.....      | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug dependency or abuse..... | <input type="checkbox"/> | <input type="checkbox"/> | Acquired Immunity Deficiency Syndrome or Human Immuno-deficiency Virus Infection ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Mental Disorder/Depression.....   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |  |                          |                          |

b. Are any eligible employees or dependents currently pregnant? .....  Yes  No

c. Are any employees or dependents scheduled for hospitalization and/or surgery? .....  Yes  No

For each item checked "Yes" above, please explain below (If more space is needed, attach a separate sheet):

| DIAGNOSIS | TREATMENT AND MEDICATIONS | LAST DATE TREATED |
|-----------|---------------------------|-------------------|
|           |                           |                   |
|           |                           |                   |
|           |                           |                   |
|           |                           |                   |

### 5. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in the Employer Risk Appraisal is complete, including attachments, and accurate to the best of my knowledge. It is further understood that any misrepresentation or false statements will subject any issued Group Contract to immediate termination by Blue Cross and Blue Shield of North Carolina.

Owner or Authorized Executive Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_