HIGHMARK. Delaware

Date: _____

New Group Questionnaire For 10 to 50 Employees

Company Name: _____

Address: _____

Nature of Business: _____ SIC Code: _____

Desired Effective Date of Coverage: _____

ENROLLMENT (1)			
	(A)	(B)	(C)
	No. of Employee/ Retirees (2)	No. Enrolling From Column A	Explanation of Difference (3)
REGULAR COVERAGE: **Active, Full-Time** *(including owners/ Do not include COBRA Employees)*			
COBRA			
Under Age 65 Retirees			
Absentee Owners, Officers/Directors, and Independent Contractors			
Part-Time			
MEDICARE SUPPLEMENT (including Carve Out)			

Name of current health insurer *(attach latest billing)*: _____

Date of next renewal: _____

Renewal Rates *(Attach renewal rates)*:

Employee $ _____ Employee & Child(ren) $_____ Employee & Spouse $_____ Family $ _____

EMPLOYER CONTRIBUTION to premium for: Employee $_____ or _____% Dependent $_____ or _____%

Brief description of current benefit: *(Attach a copy of current benefit booklet.)* _____

_____

Has the health care coverage of the company or any affiliate ever been cancelled by an insurer, or is it in the process of being cancelled by the current carrier? ❑ **Yes** ❑ **No**

If **Yes**, explain: _____

Will Highmark DE be the sole health insurer for this company? ❑ **Yes** ❑ **No**

Is there a probationary period for enrollment and employer contribution? ❑ **Yes** ❑ **No** If **"Yes"**, then length of probation: _____

(Continued on the reverse side.)

(Repeat) Your Company Name: _____

Are any of your employees or their dependents currently being treated, expect to be treated or have been treated within the last 12 months for any serious illness, such as (but not limited to):

	Yes	No		Yes	No
AIDS, ARC, HIV?	❑	❑	Congenital defect or disease?	❑	❑
Back or spinal injury?	❑	❑	Heart, kidney, liver disease?	❑	❑
Cancer?	❑	❑	Maternity, psychiatric disorder?	❑	❑
Central nervous system disease?	❑	❑	Substance abuse?	❑	❑

Employee	Dependent	Condition	Date of Occurrence	Prognosis for Recovery
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

If **"Yes"**, to any of the above, please explain: _____

_____

_____

_____

I certify that the information above and attached is complete and correct to the best of my knowledge and belief.

Signature of Company Officer: _____ Date: _____

Print Name of Company Officer: _____

Title: _____

Signature of Highmark DE Account Executive: _____ Date: _____

Title: _____

IMPORTANT NOTES:

(1) Attach a listing of covered employees including employee name; birth year; and coverage status such as Individual, Family, etc.

(2) List number of Employees/Retirees.

(3) List number of employees not enrolling as:

Probationary Period	(PP)
Covered by Spouse	(SC)
Other Qualified Insurance	(OQI) or
Not Covered	(N/C)

(4) Attach additional pages for additional information (such as claims experience), if necessary.