



Group Major Illness Questionnaire

This questionnaire must be filled out completely. Please indicate "None" if none apply. ISI will not accept the questionnaire if incomplete. Please use additional paper if necessary.

Date _____

SIC CODE: _____

COMPANY AND CURRENT PLAN INFORMATION					
Company Name					
Street Address					
City		State		Zip	
Total Number of employees on payroll:		Total Full Time:		Total Part Time:	
Total Number of current employees enrolled in Health Care Plan:					
Current Health Carrier:			Health Carrier Renewal Date: / /		
Plan Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity <input type="checkbox"/> POS <input type="checkbox"/> Self Funded <input type="checkbox"/> Other					
Are you with a PEO? <input type="checkbox"/> Yes <input type="checkbox"/> No			Any ineligible class of employees <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, name of PEO:			If yes which class:		

Please provide a complete description of your business operation:

Number of Locations: _____ **Please identify all states of operations:** _____

CURRENT PLAN CONTRIBUTION INFORMATION				
	Employee Only	Employee + Child	Employee + Spouse	Family
Number of Employees in each Coverage Level				
Company Contribution Levels				

	Most recent 12 months	13-24 months prior	Renewal Rates
Premium Rates			
Employee Only			
Employee + Spouse			
Employee + Child(ren)			
Employee + Family			
Claims Paid			
Medical (\$)			
Prescription Drug (\$)			
Total Claims (\$)			

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List any current COBRA participants (use additional paper if necessary):

NONE

Name	COBRA Effective Date	Activating Event
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to ISI Health Plan effective date:

NONE

Name	Date Eligible	Activating Event
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List any individuals who are on the health plan that are not paid employees of the company:

NONE

List any employees and/or dependents who live outside the network service area:

NONE

Name	Employee/Dependent/COBRA	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Group Major Illness Questionnaire

Please answer the following questions on behalf of your company as to the best of your knowledge (Not necessary to transfer information from Personal Health Questionnaire). You may include additional sheets for detailed explanations if necessary.

Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years, is currently hospitalized, confined at home, incapacitated, confined in a treatment facility or incapable of self-support because of physical or mental disability or been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? (If yes, please provide details below)							<input type="checkbox"/> YES <input type="checkbox"/> NO
Is anyone currently being treated or been advised to seek treatment or counseling for cancer, heart disease, chest pain, stroke, high blood pressure, liver disease, brain tumor, birth defects, transplants, kidney disorder, nervous system disorders, diabetes, AIDS, AIDS Related Complex, tested HIV positive, chronic respiratory disease, alcoholism, chemical dependency, mental illness, muscular disorder, arthritis, back disorder or other serious conditions? (If yes, circle condition and provide details below)							<input type="checkbox"/> YES <input type="checkbox"/> NO
Is anyone currently taking medication? (If yes, please list type and dosage below)							<input type="checkbox"/> YES <input type="checkbox"/> NO
Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

Group Major Illness Questionnaire

Is anyone currently pregnant? If yes, please provide due date and note below if normal, high risk, multiple birth, or preterm labor with this pregnancy.		<input type="checkbox"/> YES <input type="checkbox"/> NO
Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify ISI of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with ISI.

In the event that material information has been omitted or is inaccurate, the insurance carrier may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, the ISI service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that ISI also may adjust my insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation.

ISI gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight.

ISI Program Notice of Privacy Practices provides more detailed information about how the ISI Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The ISI Program and my health plan are not required by law to grant my request. However, if my request is granted, ISI Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the ISI Program or my health plan have already used or disclosed my protected health information in reliance upon my consent.

Information disclosed on this form is considered valid for effective dates within 90 days of date signed. I will notify ISI of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with ISI.

Authorized Signature	Title	Date
Print Name	Print Name of Company	

