



General Risk Assessment Form

Business Name: _____ Contact: _____ Date: _____

Phone #: _____ Address: _____ City _____ Zip _____

Fax #: _____ Business Type/SIC Code _____

Does the group have a current healthcare carrier? Yes No Carrier Name: _____ How long? _____

The number of employees who work over 30 hours / week: _____

The number of employees currently enrolled for coverage under your plan: _____

Does your company have a Section 125 plan which allows employees to pay for insurance premiums on a pre-tax basis? Yes No

To the best of your knowledge, please answer the following questions:

Has any employee missed 10 consecutive days of work in the past 12 months due to illness or injury? Yes No

Is any employee NOT performing his or her duties on a full-time basis due to an illness or injury? Yes No

Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within the COBRA election period:

- Currently confined at home, in a hospital, or any treatment facility? Yes No
- Had more than \$10,000 of medical expenses in the past 24 months? Yes No
- Been advised within the past 90 days to have surgery or be hospitalized? Yes No

To the best of your knowledge, has any covered employee or person within the last 2 years been treated for any of the following:

- AIDS or an AIDS-related complex or other immune system disorder Yes No Prognosis: _____
- Alcohol or drug abuse or dependence, or psychological disorder Yes No Prognosis: _____
- Cancer or cancerous tumor Yes No Prognosis: _____
- Heart or vascular disease, or stroke Yes No Prognosis: _____
- Diabetes or any disease or disorder of the kidneys, liver, or lungs Yes No Prognosis: _____
- Systemic disease such as Lupus, Multiple Sclerosis, or Muscular Dystrophy Yes No Prognosis: _____
- Organ transplant (other than corneal) Yes No Prognosis: _____
- Arthritis, Joint or Back Disorder Yes No Prognosis: _____
- Any other disease or disorder not listed above Yes No Prognosis: _____

For any "Yes" answers given to the above questions, if known, please provide additional information below for each individual.

*Class	Age	Medical Diagnosis/Condition	Dates of Treatment	Medication/Dosage	Past/Current/Future Treatment

*Class: E=Employee, D=Dependent, C=COBRA, R=Retiree

*** Plan Design (fax Summary of Benefits if possible)**

Current: HMO / PPO / Other:				Desired: HMO / PPO / Other:			
Office Visit Copay	_____	Rx Benefit	_____	Office Visit Copay	_____	Rx Benefit	_____
Network Name	_____			Network Name	_____		
Deductible	(IN) _____ (OUT) _____			Deductible	(IN) _____ (OUT) _____		
Coinsurance	(IN) _____ (OUT) _____			Coinsurance	(IN) _____ (OUT) _____		

*** IMPORTANT –Please complete and fax current carrier bill and/or fax renewal letter**

Company's Current Rates		Renewal Date:	Company's Renewal Rates	
HMO/PPO/Other	_____	Amount Employer Pays: Employee _____ % Dependents _____ %	HMO/PPO/Other	_____
Employee Only	\$ _____		Employee Only	\$ _____
Employee Child(ren)	\$ _____		Employee Child(ren)	\$ _____
Employee Spouse	\$ _____		Employee Spouse	\$ _____
Employee Family	\$ _____		Employee Family	\$ _____

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