

## Risk Appraisal

This questionnaire is designed to help us evaluate your group's coverage requirement. Please answer the questions to the best of your knowledge for the persons to be insured—employees, spouses, and dependent children.

**If the answer to any of the following questions is "yes," please explain in the space provided.**

1.  Yes  No Are you aware of any employee or dependent who has been treated, hospitalized or had surgery for a serious illness, physical or mental disorder, including but not limited to, cancer, AIDS, diabetes, cardiovascular disease, organ transplant, alcoholism, drug abuse, obesity, etc.?
  
2.  Yes  No Are you aware of any employee or dependent who has hospitalization or surgery pending or has been advised that hospitalization or surgery is necessary?
  
3.  Yes  No Are you aware of any employee or dependent who is currently disabled or not actively at work because of illness or injury?
  
4.  Yes  No Are there any employees or dependents on COBRA continuation or any handicapped children who have passed the limiting age and are currently insured by the present carrier?  
If employees are on COBRA, please describe any major medical situations.
  
5.  Yes  No Please list in space provided below any claims you are aware of that have exceeded \$5,000 in the last 12 months on any insured employee or dependent. Please provide an estimate of the amount paid, an explanation of the medical condition, and the likelihood of future claim expenses.
  
6.  Yes  No Are there any employees or dependents who are currently pregnant? If "yes," are multiple births expected?

The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. This is not an application for coverage. Any group insurance coverage will not be made effective until a proposal is made to the group, an application is completed by the group, and coverage is approved by Group Health Cooperative or Group Health Options, Inc. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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Prospective Applicant Name \_\_\_\_\_ Title \_\_\_\_\_ Signature \_\_\_\_\_

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Name of Company \_\_\_\_\_ Date \_\_\_\_\_