Network Health Plan
AFFINITY HEALTH SYSTEM

Network Health Insurance Corporation
AFFINITY HEALTH SYSTEM
Caring for health. Caring for life.

Risk Assessment Questionnaire for Employer Groups with 51-99 Employees

Company Name:		Effective Date:
Business Phone:		Date/Year Business Established:

CURRENT CARRIER INFORMATION & EMPLOYER CONTRIBUTIONS

Is this plan intended to replace any existing group Coverage? ☐ Yes ☐ No	
Anniversary date of current carrier:	Proposed termination date of current group carrier:
Is there an HRA plan currently in effect? ☐ Yes ☐ No	If yes, what dollar amount?
Are multiple medical plans being offered? ☐ Yes ☐ No	Is there a Section 125 plan in effect?☐ Yes ☐ No

Carrier name(s):	Benefit Plan (check all that apply)	Employer Contributions (% or $)	
	☐ HMO ☐ POS ☐ PPO ☐other	Employees	Dependents
	☐ HMO ☐ POS ☐ PPO ☐other		

If contributions are based on another method, please describe:

Please indicate your current and renewal health rates below and attach a copy of your renewal, Bill/notice/statement (unless already submitted).

Current Rates	S:	E/C:	E/S:	F:	Effective date:
Renewal Rates	S:	E/C:	E/S:	F:	Effective date:

MEDICAL INFORMATION: PLEASE ANSWER TO THE BEST OF YOUR ABILITY

Have there been any claims in excess of $25,000 total per covered individual (employee, retiree, COBRA continuant or their dependents) during the past 2 years, or have any covered individuals been confined to the hospital for 10 consecutive days during the past 3 years?	☐ Yes ☐ No
Do you anticipate any pending $25,000+ claims or 10= day confinements within the next 12 months?	☐ Yes ☐ No
Are any covered individuals currently confined to a hospital, or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?	☐ Yes ☐ No
Have any covered individuals consulted or received treatment by a doctor within the last 24 months for; cancer, stroke, heart, vascular disease? Disorders of the liver, kidney, lungs or immune system; alcohol, or substance abuse?	☐ Yes ☐ No
Are there any employees or dependents who are currently disabled?	☐ Yes ☐ No
Are there any covered individuals current in a structured mental illness/chemical dependency program?	☐ Yes ☐ No
Are there any dependent children currently covered under the plan that exceed the maximum age limit? (dependents with mental or physical handicaps)	☐ Yes ☐ No

If YES to any of the above, please provide the following information for each:

Date of Birth	M/F	Medical Condition	Date of onset	Amount Paid	Current Status/Diagnosis of patient

(continue on reverse)

SECTION 504 (F) REPRESENTATION

The company understands that NHP and its representatives may contact individuals eligible for coverage to obtain additional follow-up information. The company agrees to inform eligible individuals that NHP may contact them in order to obtain additional information or to discuss information provided on this form. The company agrees to indemnify NHP and its representatives for any liability or damages resulting from any breach of representation made in this form and for claims brought by individuals eligible for coverage regarding the use of the information disclosed by the company.

The company represents, as the plan sponsor of its group health plan, that any employee of the company requesting protected health information ("PHI") within the meaning of the "Standards for Privacy of Individually Identifiable Health Information" set for at 45 C.F.R. parts 160 and 164 ("the Privacy Rule") about a covered individual from NHP is acting in an administrative capacity for the group health plan and not for the company. The company further represents that if an employee of the company requests "HI from NHP, the company will have provided the certification to it's group health plan and amended its plan document in accordance with Section 504(f) of the Privacy Rule and documented, among other things, its uses and disclosures of PHI, the individuals or classes of employees who are involved in plan administration and have access to the PHI and shall have represented that the PHI will not be used in employment decisions.

STATEMENT OF UNDERSTANDING AND AUTHORIZED COMPANY REPRESENTATIVE SIGNATURE

The company understands and agrees that this Risk Assessment Questionnaire in no way obligates NHP to offer group health insurance to the company. Further, coverage may be rescinded if there are misstatements, fraudulent or otherwise in this questionnaire.

Any person who presents or prepares any statement, document or claim and the person knew or should have known the statement, document or claim contained materially false, incomplete or misleading information concerning the rating of an insurance policy or the application for the issuance of an insurance policy is guilty of insurance fraud. WI Stat 895.486(1)(a)(e)

I understand and do hereby certify that the information contained in this Risk Assessment Questionnaire is complete and accurate to the best of my knowledge. It is further understood that Network Health Plan reserves the right to re-rate or rescind coverage if any supplied information is materially inaccurate or incomplete, even if unintentional.

Print Name of Company: ______________________________

By: ______________________ ______________________ __________

Signature of Authorized Company Representative | Print Name and Title | Date

(company executive or senior Human Resource Employee)

Reviewer: *(completed by Network Health Plan Representative)*

______________________ ______________________ __________

Signature of Account Executive | Print Name | Date

Underwriting:

______________________ ______________________ __________

Signature of assigned Underwriter | Print Name | Date