KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20849

Group Risk Questionnaire

This is a required form and must be completed by all midsize to large groups. (51 or more eligibles)

A. Company Information

Group Name: _____ Effective Date: _____
Group Address: _____ City, State, Zip: _____
Broker: _____ Incumbent Broker: Yes / No _____
Current Carrier: _____ How many Years? _____ Number of Carriers in the Past 3 Years?: _____
Current Plan Design: _____ (Please attach Plan Summary Description and Census)
Nature of Business / SIC Code: _____

B. General Information – Claims, Rate History, and Eligibility Criteria

Rates	Current HMO	Current POS/PPO	Renewal HMO	Renewal POS/PPO	ER Contribution %
Subscriber	$	$	$	$	
Subscriber/Spouse	$	$	$	$	
Subscriber/Child(ren)	$	$	$	$	
Family	$	$	$	$	
% of Renewal Increase:					

Number of Active: _____
Number of Cobra: _____
Number Early Retiree/Retired: _____
Number of Waivers: _____
Total Number of Eligibles: _____

New Hire Waiting Period: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other: _____

- **Please provide group claims experience and rate history for the past 36 months (200 eligibles or more).**

C. Medical Profile

Serious Medical Conditions - As an employer are you aware of any employee or dependent of an employee, including those not enrolling for coverage, who has been diagnosed or treated for any of the following conditions? **Please mark the number of employees/dependents next to the appropriate condition.** Include additional details, if available, in space provided below or on the reverse side of this document.

#	Condition
	AIDS/ARC or Acquired Immune Deficiency Syndrome – Explain below
	Birth Abnormalities / Birth Injuries
	Blood Disorders, i.e. Hemophilia, Leukemia, etc. –Explain below
	Cancer/Cancerous Tumor / Skin Cancer – Explain below
	Recovered: Yrs. Type:
	Chest Pain/Congestive Heart Failure/Coronary Artery Disease/ Bypass – Explain below
	Chronic Obstructive Lung Disease, i.e. Emphysema, Bronchitis, etc. – Explain below
	Diabetes – Type/Treatment:
	Epilepsy / Seizures – Type/Treatment:
	Kidney Disorders/Kidney Stones/Polycystic Kidney Disease - Dialysis/Renal Failure – Explain below

#	Condition
	Liver Cirrhosis / Liver Disorders / Pancreas – Explain below
	Lupus – Explain below
	Mental Nervous Disorders / Mental Illness / Depression / Substance Abuse
	Multiple Sclerosis / Muscular Dystrophy
	Paralysis – Explain below
	Pregnancy Due Date:
	Stomach or Bowel Disorders, i.e. Ulcer / Crohn's disease, Ulcerative colitis, etc.
	Stroke (Cerebral)
	Transplant (Done/Pending)Cornea/Liver/ Kidney/Heart/Lung - Explain below
	Tumor, Cysts – Benign / Malignant – Explain below

- Are you aware of any other serious medical conditions, not listed above? Has any employee or dependent of an employee been hospitalized or received medical treatment within the past 12 months? If yes, explain below.
- Are there any employees, currently not actively at work or unable to perform their normal work duties due to a disability or work-related injury? If yes, explain below.

Describe or Answer Any Illness/Condition related Questions from Above
If additional space is needed to respond to any question, please provide response on separate page and attach.

To the best of my knowledge and belief, the answers to the above questions are true.

Group Signature: _____ Title: _____ Date: _____
Broker: _____ Company: _____ Date: _____
Sales Representative: _____ Date: _____