M.D. IPA
The Quality Care Health Plan

OPTIMUM CHOICE
HEALTH PLAN

alliance
PPO, INC

GROUP RISK ASSESSMENT

Application is hereby made for group coverage for eligible employees and their eligible dependents based on the following information:

Company Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone: _____

Company Official: _____ Title: _____

Person to Contact: _____ Title: _____

Nature of Business: _____

Total No. of Employees: _____ Full-time: _____ Part-time: _____ Union: _____

Total number of eligible employees: _____ Number enrolled: _____

1. Full-time is defined to be employees working a minimum of _____ hours per week on a regular year-round basis.
2. Average number of full-time employees for the past two years: _____.
3. Are union employees covered by another plan? ☐ YES ☐ NO
4. Are 50%, or more, of your employees family members? ☐ YES ☐ NO

What is the average age of the enrolled employees? _____ Requested effective date: _____

Are all eligible employees actively at work? ☐ YES ☐ NO

Do you have any employees age 65 or over actively at work? ☐ YES ☐ NO

NOTE: Verification of employment/number of hours is required for all employees age 65 or over.

COMPANY WAITING PERIOD: _____ **(This is the amount of time an employee must be employed before being eligible for benefits.)**

Employer premium contribution to: Employee coverage: _____%; Dependent coverage: _____%

NOTE: It is agreed that if the employer pays the entire cost of the coverage, 100% of the eligible employees must be covered. The employer agrees to make monthly payroll deductions for the employee contributions, if any, for each employee enrolling in the benefit program.

Are there any current or prior employees or dependents covered under COBRA? ☐ YES ☐ NO
If YES, how many? _____ (Please indicate on employee application)

Do you have any employees or any knowledge of employees' dependents who live out of the area and who require health coverage? ☐ YES ☐ NO
If YES, number of employees or dependents and where they are located:

_____

_____

Has your group been declined for health coverage in the past 2 years? ☐ YES ☐ NO
If YES, reasons: _____

_____

PLEASE ANSWER THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE:
Are you aware of any employees or dependents (including individuals covered under COBRA) that:

1. Are currently disabled? ☐ YES ☐ NO
   If YES, please complete the following:
   DESCRIBE CONDITION — DATE EXPECTED TO RETURN TO WORK

   _____ _____

   _____ _____

2. Had any claims paid in the last 12 months equal to or greater than $5,000? If YES, please show amount and describe condition causing claim. If additional space is needed, please attach a separate sheet ☐ YES ☐ NO
   AMOUNT — CONDITION

   $_____ _____

   $_____ _____

3. Have potential health or life threatening conditions other than stated elsewhere on this form? ☐ YES ☐ NO

4. Are scheduled or advised to be hospitalized and/or have surgery? ☐ YES ☐ NO
   If YES, please describe the condition including age, treatment, medication and prognosis:

   _____

   _____

5. Are currently pregnant? If YES, how many_____ Expected delivery date (s) _____ ☐ YES ☐ NO
   Any current or anticipated complications? If YES, please give details ☐ YES ☐ NO

   _____

   _____

6. Might be considered developmentally disabled or physically handicapped or have a birth defect? ☐ YES ☐ NO
   If YES, please describe the condition including, age, treatment, medication and prognosis:

   _____

   _____

7. Have a mental illness or any mental health condition for which they have been told to seek treatment or for which they are receiving or have received any form of treatment? ☐ YES ☐ NO
   If YES, please describe the condition including, age, treatment, medication and prognosis:

   _____

   _____

8. Have received treatment for or have used (or are currently using): alcoholic substances or drugs, including, but not limited to, marijuana, cocaine, heroin, amphetamines ("speed"), barbiturates ("downers"), or have abused prescription drugs?
   ☐ YES ☐ NO
   If YES, please describe:

   _____

   _____

The statements herein are represented to be true and complete and is acknowledged that such statements of the Employer will be relied upon in the assessment of risk. This is not a contract. Completion of this application does not constitute any obligation on either party's behalf.

Should the undersigned Employer fail to qualify as an eligible Employer, any monies paid by or on account of the undersigned for the purposes specified above shall be returned, to the extent unexpended and there shall be no further obligation on the part of either party.

_____ _____

DATE — EMPLOYER SIGNATURE