



MBA & BIAW Risk Appraisal Form

Please answer each question to the best of your knowledge for all prospective enrollees including: owners, employees, spouses, dependent children, domestic partners and COBRA participants. This form will not be accepted without all questions being answered. If the answer to any question is "yes," please use the additional space to provide specific information (however, do **NOT** include names or social security numbers).

WELLNESS PROGRAMS

- 1) Does your company offer wellness programs for your employees? Yes No If so, please select all that apply:
- Drug / alcohol screenings** **On-site flu shots** **Cholesterol screenings** **Blood pressure checks**
- Blood glucose screenings** **Preventive Safety Classes** **Stop smoking programs** **Other:** _____

RISK FACTORS

- 2) Are you aware of any enrollees or prospective enrollees that have been treated, hospitalized or had surgery for a serious illness over the last 12 months? These include, but are not limited to: cancer, AIDS, diabetes, cardiovascular disease, transplant, mental disorders, alcoholism, drug abuse, obesity, etc. Yes No

If yes please supply additional information: _____

- 3) Are you aware of any enrollees or prospective enrollees that have a hospitalization or surgery pending or have been advised that hospitalization or surgery is necessary? Yes No

If yes please supply additional information: _____

- 4) Are you aware of any current or prospective enrollees that are currently disabled or not actively at work because of illness or injury? Yes No

- 5) Are there any prospective enrollees on COBRA continuation coverage? Yes No If yes, how many _____

- 6) Are you aware of any claims that have exceeded \$25,000 in the last 12 months on any enrollees or prospective enrollee? Yes No

If so please provide an estimate of the amount paid, an explanation of the medical condition, dates, and the likelihood of future claim expenses or ongoing treatment requirements.

- 7) Are you aware of any enrollees or prospective enrollees with an existing pregnancy? Yes No
If "yes" are multiple births expected? Yes No

- 8) Are there any handicapped children who have passed the limiting age and are currently insured? Yes No

By completing this form I certify that the above information is correct to the best of my knowledge. This is not an application for coverage. If a contract for coverage is issued and it is determined that false, incorrect, or incomplete information has been provided, and if as a result of correcting the information the Group no longer qualifies for the Rate quoted, I understand that the provider will have the right to adjust the rates. 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 the MBA/BIAW Trust Carriers.

Name of Individual Completing Form

Title

Signature

Name of Company

Date