Employer Questionnaire

blue of california

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

For 15 to 50 enrolling employees

Please fax back to: _____

Group name: _____

Proposed effective date: _____

For UW use only:

Probable RAF _____ Date _____ UW _____

Final RAF _____ Date _____ UW _____

Has the group been covered by Blue Shield in the past 12 months? ☐ Yes ☐ No

Type of business (SIC): County location:

What percent of the health coverage cost is paid by the employer?
For employees: % For dependents: %

Complete the following questions for your employees and their dependents including those with COBRA/CalCOBRA. Please respond to the best of your knowledge – you are not required to obtain information from employees.
Notice: Information provided by the employer on this form is relied upon by Blue Shield to provide a probable Risk Adjustment Factor (RAF) and quote to the group. In addition, Blue Shield may review prior Blue Shield claims history. Acceptance of a quote constitutes only a preliminary agreement between the parties. Blue Shield reserves the right to adjust the proposed RAF and rates based on actual enrollment in order to execute a definitive agreement.

1	Employee eligibility Total number of employees _____ (excluding COBRA/CalCOBRA) Number of COBRA/CalCOBRA participants _____ Number of participating employees _____ Number of ineligible employees _____ Number of full-time employees _____ Number of participating dependents _____		
		Yes	**No**
2	Is any person to be covered unable to work due to injury or illness?	☐	☐
3	Is any person unable to perform the normal duties in their customary employment or activity?	☐	☐
4	Are any dependent children incapable of self-support because of physical or mental disability?	☐	☐
5	Is any person currently hospitalized or been told extensive medical treatment, surgery, or hospitalization is required?	☐	☐
6	Is any person being treated for heart disease, stroke, cancer, kidney disorder, AIDS, AIDS-related complex, chronic respiratory disease, or other serious condition?	☐	☐
7	Has any person suffered a condition that resulted in expenses of $5,000 or more, or been hospitalized during the past 24 months?	☐	☐
8	Is there any person being treated for alcoholism or chemical dependency or been advised to seek treatment?	☐	☐
9	Is any person currently pregnant? How many? Due date(s)	☐	☐
10	Are any persons included who are not employees for the purpose of workers' compensation law or similar legislation? If yes, provide name and title.	☐	☐
11	Do you have COBRA/CalCOBRA applicants? Please indicate date(s) of qualifying event and reason.	☐	☐
12	Are any participants not subject to W-2 withholding? If yes, please explain.	☐	☐
13	Does your company provide current health coverage? Please indicate which company or companies	☐	☐
14	Do you want a Dual Option, Suite Deal, or PlanSelect quote? If yes, list Plan(s)	☐	☐

For each question answered yes, please provide additional information page 2.

(continued on page 2)

An Independent Member of the Blue Shield Association C15146-PR (3/10)

Employer Questionnaire *(continued)*

No genetic information, including family medical history, and no information related to HIV testing should be provided. California law prohibits an HIV test from being required or used by health insurance companies or heathcare service plans as a condition of obtaining health coverage.

(Please print)

Please indicate below which questions you are explaining.

Q.#	
Q.#	
Q.#	
Q.#	
Q.#	

The undersigned hereby acknowledge that to the best of their knowledge and belief, all of the responses given above are true, correct, and complete. Once this group is accepted, this document becomes part of the group application. Blue Shield of California/Blue Shield Life may, at its discretion, adjust the rates retroactively if misstatements are made.

Company officer/owner name and title	Signature of company officer/owner	Date
Broker/agent name	Signature	Date