

Employer Questionnaire



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

For 15 to 50 enrolling employees

Please fax back to: _____

Participation and eligibility requirements apply.

Employee information to be completed by employer.

For UW use only:

Probable RAF _____ Date _____ UW _____

Final RAF _____ Date _____ UW _____

Group Name:	Proposed effective date:
Has the group been covered by Blue Shield in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of business (SIC):	County location:
What percent of the health coverage cost is paid by the employer? For employees: % For dependent: %	

Please answer each question for your employees and/or dependents, including those who elect COBRA. The group and/or individual subscriber member must still meet requirements as defined by AB1672 (eligibility is confirmed prior to enrollment.)
Notice: This is not a final quote – The RAF is based on the information submitted. Should any member have prior Blue Shield coverage, there will be a review of prior claims history. Any changes in the below enrollment numbers and any prior claims may impact the final RAF at the time the new group is submitted.

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

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

(continued on page 2)

Employer Questionnaire *(continued)*

HIV Testing Prohibited: California law prohibits a HIV test from being required or used by a health insurance company or health care service plan 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.

Employer's Name and Title

Signature of Company Officer/Owner

Date

Broker/Agent Name

Signature

Date