# Group Health Benefits Evaluation and Selection Survey

**Fields marked with an asterisk "*" are required. This form must be filled out completely. Please be sure to indicate "None" if applicable. Incomplete forms will not accept be accepted. Use additional paper if necessary.**

| I. COMPANY AND CURRENT ENROLLMENT INFORMATION | | | | | |
|---|---|---|---|---|---|
| * Today's Date | | Proposed Effective Date | | | |
| * Company Name | | | | | |
| * Street Address | | | | | |
| * City | | * State | | * Zip | |
| County | | Point of Contact Name & Phone # | ( ) - | | |
| *Total Number of employees on payroll: | | * Total Full Time: ____ | * Total Part Time: ____ | | |
| *Are any health plan enrollees NOT paid employees (other than spouses or children)? Yes ☐ No ☐<br>*** If yes, please provide names and details: | | | | | |
| * Current Health Carrier: | | * Health Carrier Renewal Date: / | | | |
| * Are any health plan enrollees NOT paid employees (other than spouses or children)? Yes ☐ No ☐<br>***If yes, please provide names and details: | | | | | |
| * Are you currently with a Professional Employer Organization? Yes ☐ No ☐<br>* If yes, name of PEO: | | * Any ineligible class of employees)?<br>Yes ☐ No ☐ If yes, which class: | | | |
| Please provide a complete description of your business operation: | | | | SIC Code: | |
| * Number of Locations: _____ | | *Please identify all states of operation: | | | |
| * Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company or a PEO? Yes ☐ No ☐<br>* If yes, please briefly explain the reason why and when this occurred: | | | | | |

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**A.** List any current participants in COBRA / State Continuation or out on the Family and Medical Leave Act (use additional paper if necessary): **None** ☐

| Name of Individual | COBRA / Continuation Effective Date | Activating Event / Date (i.e. employee termination, etc.) |
|---|---|---|
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**B.** List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date (use additional paper if necessary): **None** ☐

| Name | Date Eligible | Activating Event / Date |
|---|---|---|
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**C.** List any employees and/or dependents who are on the health plan that are disabled:

**None** ☐

| Name | Date Eligible | Activating Event / Date |
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| **II. RATE HISTORY** (if more than 3 plans, include the 3 most popularly-elected plans) | | | | |
|---|---|---|---|---|
| **Plan 1 Name: _____** | **# Enrolled: _____** | **Renewal Rates (eff. __/__/____)** | **Most recent 12 months** | **13-24 months prior** |
| **Premium Rates** | | | | |
| Employee Only | # | $ | $ | $ |
| Employee + Spouse | # | $ | $ | $ |
| Employee + Child(ren) | # | $ | $ | $ |
| Employee + Family | # | $ | $ | $ |

| **Plan 2 Name: _____** | **# Enrolled: _____** | **Renewal Rates (eff. __/__/____)** | **Most recent 12 months** | **13-24 months prior** |
|---|---|---|---|---|
| **Premium Rates** | | | | |
| Employee Only | # | $ | $ | $ |
| Employee + Spouse | # | $ | $ | $ |
| Employee + Child(ren) | # | $ | $ | $ |
| Employee + Family | # | $ | $ | $ |

| **Plan 3 Name: _____** | **# Enrolled: _____** | **Renewal Rates (eff. __/__/____)** | **Most recent 12 months** | **13-24 months prior** |
|---|---|---|---|---|
| **Premium Rates** | | | | |
| Employee Only | # | $ | $ | $ |
| Employee + Spouse | # | $ | $ | $ |
| Employee + Child(ren) | # | $ | $ | $ |
| Employee + Family | # | $ | $ | $ |

| **III. CURRENT PLAN BENEFIT SUMMARY INFORMATION** (Individual, in-network only) | | | |
|---|---|---|---|
| **Current Plan Names:** | **1:** | **2:** | **3:** |
| **Current Plan Types:** | HMO ☐ PPO ☐ HDHP ☐ POS: ☐ Other: | HMO ☐ PPO ☐ HDHP ☐ POS ☐ Other: | HMO ☐ PPO ☐ HDHP ☐ POS ☐ Other: |
| **Annual Deductible** | | | |
| **Co-Insurance (as %)** | | | |
| **Out-of-Pocket Max** (excluding deductible) | | | |
| **Office Visit Copay** | | | |
| **Prescription Drug Copay** generic / brand formulary / brand non-formulary | **/ /** | **/ /** | **/ /** |

| **IV. CURRENT PLAN CONTRIBUTION INFORMATION** | | | | |
|---|---|---|---|---|
| | Employee Only | Employee + Spouse | Employee + Child | Family |
| **Company Contribution Levels (by $ or %)** | | | | |

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# Group Health Benefits Evaluation and Selection Survey

Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations

| **GENERAL ILLNESS QUESTIONS:** | * To the Best of My Knowledge (any or all) |
|---|---|
| a) Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five (5) years?<br>b) Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility or incapable of self-support because of physical or mental disability?<br>c) Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?<br>***(If yes to any or all, please provide details in the table below)*** | Yes ☐<br>No ☐ |

**SPECIFIC ILLNESS QUESTION:**

* Is anyone currently being treated or been advised to seek treatment for any of the following?

* Please check all that apply:

- ❑ AIDS or testing HIV Positive
- ❑ arthritis
- ❑ back disorder
- ❑ cancer
- ❑ diabetes
- ❑ heart disease
- ❑ hemophilia
- ❑ kidney disorder
- ❑ liver disease
- ❑ mental illness
- ❑ muscular disorder
- ❑ nervous system disorders
- ❑ respiratory disease
- ❑ stroke
- ❑ substance dependency
- ❑ transplants
- ❑ tumor
- ❑ other serious conditions

***(If any boxes are checked, please provide details in the table below)***

| Name | Sex | Date of Birth | Condition | Date of Onset | Last Date Treated | Treatment/ Drug | Degree of Recovery |
|---|---|---|---|---|---|---|---|
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Known Medical Conditions to the best of your knowledge (continued):

| * **IS ANYONE CURRENTLY PREGNANT?**<br>If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy.<br><br>*This includes employees, dependents or COBRA participants.* | *To the Best of My Knowledge:<br><br>❑ YES ❑ NO |
|---|---|

| Name | Due Date | Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.) |
|---|---|---|
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## V. EMPLOYER'S PLAN OPTION

Clients are required to pay up to the monthly Estimated Employer Plan Claim Costs. This amount is based on Estimated Employer's Plan Claim Costs for the Agreement Period (including the Aggregate Stop Loss Percentage). If the Plan's actual employee claim experience is less than the Estimated Employer Plan Claim Costs collected, then a Claim Funding Surplus occurs. The final Claim Funding Surplus amount will be determined as part of your Plan's Year End Accounting at the end of the twelve (12) month run-out period. If the 50% surplus option is selected, Nationwide will retain as a deferred administrative fee one-half of the amount by which Estimated Claim Costs exceed Actual Claim Costs made during the Plan Year. Following renewal Nationwide Excess Stop-Loss Policy offering, the remaining one-half will be returned to the Employer's Plan. If the 100% surplus option is selected, following renewal or upon termination, any Claim Funding Surplus amount will be returned to Client. If the Plan's actual claim experience is higher than the maximum Estimated Claim Costs collected, Eligible Claim Expenses will be covered under the Stop Loss Policy.

When the plan chooses the 50% of the employer's claims reserve surplus option the Excess Loss Premium will be reduced when compared to the Premium charged for the 100% employer claim reserve surplus option. In the case where the Plan chooses the calendar year option the Plan will credit the employees previous plan year out of pocket and deductible paid expense incurred in the current plan year to the calendar year new employer's self-funded benefit plan. The employee must provide within the first six months of new coverage E.O.B.'s of eligible medical expenses to receive said credits. The administration fees will be .25 cents per employee per month for this option

| | |
|---|---|
| I choose the 50% option: _____<br>(Initials) | I choose the 100% option: _____<br>(Initials) |
| I choose the Calendar Year option: _____<br>(Initials) | I choose the Plan Year option: _____<br>(Initials) |

Initials: _____

# Group Health Benefits Evaluation and Selection Survey

## Agreement to Enroll for Coverage

### AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: please read this authorization form carefully before signing. Your request to enroll for coverage cannot be processed without your signature. You have the right to receive a copy of this form following your signature.

**I. Protected Health Information**

Nationwide Insurance Company and its affiliates are committed to the privacy of your PHI/Personal Information and has required all business associates and vendors to agree in writing to those same protections. Despite these efforts we are required by law to advise you that your Information may at some point fall outside of these protections, be re-disclosed and would no longer be protected.

This authorization encompasses information that is considered to be Protected Health Information and/or Personal Information. Protected Health Information (PHI) includes individually identifiable health information that is created or received by your provider, health plan or insurer, data clearinghouse, a health authority, employer, school or university, pharmacy or pharmacy benefit managers.

PHI/Personal Information relates to the past, present, or future condition of your physical or mental health, healthcare provided to you, or payment for the healthcare provided to you. PHI/Personal Information does not include summary health information or information that has been de-identified according to the standards for de-identification provided for in the Health Insurance Portability and Accountability Act privacy rule.

By signing this form, I authorize certain entities identified below to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records and alcohol and/or drug abuse records. Protected health information may be obtained, maintained, or transmitted in any form or medium, including written, oral, or electronic.

**II. Purpose of the Authorization Form**

By signing this form, I authorize the use and disclosure of protected health information for the purposes of: determining eligibility for enrollment or benefits under a health plan; determining eligibility and/or risk-rating of stop-loss insurance coverage for my employer, or to allow the plan's designee to conduct utilization review and quality improvement activities ("Purpose").

**III. Entities Authorized to Use and Disclose My Protected Health Information**

I hereby authorize the following entities, their reinsurers, or other organizations performing business or legal services in connection with the Purpose above and their respective legal representatives ("Entities") to receive, use, and disclose my protected health information for the Purpose listed above:

**The Excess Stop-Loss Insurance Company**

**United States Managing General Underwriters**

I authorize Entities to disclose my PHI between themselves and their affiliated companies, to reinsuring companies, to the plan administrator or plan sponsor.

I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, pharmacy or pharmacy benefit managers or other medical or medically related facility, insurance or reinsuring company, or other organization that has any record or knowledge of me to give Entities any and all PHI about me concerning diagnosis, treatment and prognosis for any physical or mental condition, including, but not limited to, all medical and healthcare records.

I understand I have a right to inspect and copy my own PHI/Personal Information to be used or disclosed. I understand that failure to sign this Authorization will result in my application not being considered.

I understand that my Personal Representative or I have a right to receive a copy of the authorization form. A simulated, faxed or copied image of this Authorization shall be as valid as the original.

**IV. Term of Authorization**

I further agree this Authorization will be valid until the Entities or their affiliates have completed their underwriting of my employer's coverage or for 12 months from the date signed, whichever is less.

**V. Right to Revoke**

I understand I may revoke this authorization at any time by giving advance written notice to the Entities listed above. Revocation of this authorization form will not affect actions Entities took in reliance on this form prior to receipt of the written notice of revocation.

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I certify that the statements herein are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify the entity collecting this information of any changes that occur after signing this Group Health Questionnaire and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement will be terminated for breach.

This information is gathered for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

| | | |
|---|---|---|
| * **Authorized Signature** | * **Title** | * **Date** |
| * **Print Name** | * **Print Name of Company** | * **Initials** |
| **Broker / Sales Signature** | **Broker / Sales Print Name** | **Date** |

**Client Privacy Notification**

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detailed health information that you provide via hard copy or through any electronic means will be used solely for the purpose of providing risk assessment to the employer's self-funded plan and excess stop-loss carrier and is subject to certain provisions of the Health Insurance Portability and Accountability Act privacy rule of 1996 (HIPAA) regulations.

**IMPORTANT NOTICE: PLEASE READ AND RETAIN**

**Annual Open Enrollment Period**

Eligible employees may enroll themselves and their eligible dependents during the annual open enrollment period, which is the month prior to the start of the new plan year.

Initials: _____