



GROUP RISK QUESTIONNAIRE

(FOR GROUPS OF 26 EMPLOYEES AND MORE)

NAME OF BUSINESS:	
INDUSTRY TYPE:	
ADDRESS:	
CITY, ZIP CODE:	
RENEWAL DATE:	

HEALTH INFORMATION

A. Please provide the answers to the following questions as they pertain to all eligible employees and covered dependents.

To your knowledge has any person to be covered been diagnosed or treated by a provider for any of the following conditions within the last five years?

	YES	NO	# OF PEOPLE
1. Alcohol or substance abuse			
2. Arthritis			
3. Asthma, Emphysema, Cystic Fibrosis or other lung disease			
4. Diabetes: Type I or II			
5. Cancer: Type (if known)			
6. Epilepsy			
7. Disorder of the spine, back or joints			
8. High Blood Pressure			
9. Heart Disease			
10. Stroke, Paralysis			
11. Kidney or Bladder Disease, Kidney Dialysis			
12. Liver Disease or Hepatitis: Type (if known)			
13. Multiple Sclerosis, Muscular Dystrophy or Cerebral Palsy			
14. Psychological or other Mental Disorder			
15. Organ Transplant (planned or past)			
16. Tuberculosis			
17. Colitis or Crohn's Disease			

B. Have any employees or dependents, who are eligible for coverage, incurred claims that have exceeded \$10,000 (medical and/or pharmacy) during the last 12 months: yes or no

C. Are any eligible employees or dependents currently pregnant: yes or no How many:

D. For each item checked "yes", please explain in section E on the next page.

