Employer Risk Appraisal Questionnaire

(Groups 36+ enrolled employees)

Administered by Coventry Health Care of Louisiana, Inc.

Employer Risk Appraisal Questionnaire

Groups 36+ Employees

This questionnaire is designed to provide information specific to your group and will be used by Coventry Health Care of Louisiana, Inc./Coventry Health and Life Insurance Company (CHCLA/CHL) in evaluating the risk characteristics to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.

I. GENERAL INFORMATION

Company Name

Company Address

City/State/Zip

Phone Number	Requested Effective Date
Nature of Business & SIC	Years in Operation

Reason Out to Bid

Please list any employer locations other than noted above.

II. GROUP ELIGIBILITY

Total Employees	Total Eligible for Coverage	Total Waivers	
Full-time	Part Time	Retiree	COBRA

Please see your CHCLA/CHL rate proposal for complete eligibility and quoting policies.

Please identify on census or attach a list of all:

- COBRA: former employees and/or dependents covered or eligible to receive coverage under state or COBRA continuation. Please list employees' termination date.
- Retirees: if eligible for coverage with CHCLA/CHL
- Out of Area employees/members applying for coverage with CHCLA/CHL.

Employer Contribution: Employee	Dependent

Waiting Period

Are all eligible employees covered by Workers' Compensation? ❑ Yes ❑ No

If no, please explain:

III. COVERAGE INFORMATION (List all health carriers in the last three years)

Carrier	Effective Date	Reason for Change

RATES	Employee	EE/Spouse	EE/Child(ren)	Family	Plan Description*
Current	$	$	$	$	
Renewal	$	$	$	$	

***Please attach** a current benefit summarie(s) for the most recent 2-year period.

Previously covered by CHCLA/CHL? ❑ Yes ❑ No If yes, date covered: ___________________.

IV. HEALTH INFORMATION

Provide the answers to the following questions as they pertain to all eligible employees and/or covered dependents (including COBRA, any state continuation programs, and eligible retirees).

A. To your knowledge has any person (employee and/or employee's dependents*, or COBRA individuals*) to be covered been diagnosed or treated for any of the following conditions within the last 5 years? **(Please check Yes or No. If yes, please circle all conditions that apply.)**

Condition	Yes	No	# of people
1. Alcohol or substance abuse	❑ Yes	❑ No	# of people: _______
2. Arthritis	❑ Yes	❑ No	# of people: _______
3. Asthma, emphysema, cystic fibrosis, or other lung disease	❑ Yes	❑ No	# of people: _______
4. Diabetes: Type (if known)_______________	❑ Yes	❑ No	# of people: _______
5. Cancer	❑ Yes	❑ No	# of people: _______
6. Epilepsy/seizure disorder	❑ Yes	❑ No	# of people: _______
7. Disorder of the spine, back, joints, bones	❑ Yes	❑ No	# of people: _______
8. High blood pressure	❑ Yes	❑ No	# of people: _______
9. Heart disease	❑ Yes	❑ No	# of people: _______
10. Stroke, paralysis	❑ Yes	❑ No	# of people: _______
11. Kidney or bladder disease, kidney dialysis	❑ Yes	❑ No	# of people: _______
12. Liver disease or hepatitis: Type (if known)________________	❑ Yes	❑ No	# of people: _______
13. Multiple sclerosis, muscular dystrophy, or cerebral palsy	❑ Yes	❑ No	# of people: _______
14. Psychological or other mental disorder	❑ Yes	❑ No	# of people: _______
15. Organ transplant (planned or past)	❑ Yes	❑ No	# of people: _______
16. HIV/AIDS or any autoimmune disease	❑ Yes	❑ No	# of people: _______
17. Tuberculosis	❑ Yes	❑ No	# of people: _______
18. Colitis or Crohn's disease	❑ Yes	❑ No	# of people: _______
19. Any condition or disease not mentioned above, *or any anticipated surgery*	❑ Yes	❑ No	# of people: _______

For each item checked "YES," please explain in section D on the back of this page.

B. Have any employees, dependents, or COBRA individuals who are eligible for coverage incurred claims that have exceeded $10,000 (medical and/or pharmacy) during the last 12 months?
❑ Yes ❑ No **Please explain in section D.**

Are any employees currently disabled or otherwise not actively-at-work? (Give medical details and date disability started.)
❑ Yes ____ ❑ No

C. Are any eligible employees or dependents currently pregnant?

❑Yes How many? _____ Ages __________ Due Dates ____________________ ❑ No

D. Please explain any "YES" answers in this space. Please indicate what question you are answering. **If more space is needed, attach a separate sheet. Please sign and date all attachments.**

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V. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in this Employer Risk Appraisal Questionnaire is complete and accurate to the best of my knowledge. I further certify that I hold a position with the company that permits me to have the information necessary to complete this Employer Risk Appraisal Questionnaire on behalf of the company or I have conferred with and confirmed my answers with person(s) that hold such position(s) with the company. It is further understood that CHCLA/CHL reserve the right to re-rate or rescind coverage if any supplied information is materially inaccurate or incomplete, even if unintentional.

I understand that CHCLA/CHL may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that CHCLA/CHL may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify CHCLA/CHL for any liability or damages resulting from any breach of representation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by employer.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature___________________________________ Print Name _____________________________________

(Company executive or senior Human Resources employee) Title ____

Phone number ____ Date Signed ______________________