

**GROUP MEDICAL RISK QUESTIONNAIRE
FOR UNDERWRITING**



MANAGED BENEFITS
INCORPORATED

Group Name:	
Name and Title of Person Completing:	
Date:	

For all “yes” answers please provide details (claimant’s current status) beneath question. YES NO

1. Have any claims over \$ 5,000 been paid in the past 12 months?

2. Have any employees been hospitalized in the past 12 months? How many?

3. Are there presently any on-going disabilities?

4. How many employees are not actively at work due to disability?

5. How many employees or spouses are currently pregnant?

6. Are you aware of any pending or planned hospitalizations or surgeries?

7. Are you aware of any plan members who have been diagnosed with or received treatment for **any of the following conditions** in the past three (3) years?

Condition	Yes	No	Age of Person	Status
a. Alcohol/Chemical Dependency				
b. Arthritis				
c. Cancer (include type)				
d. Diabetes (note if insulin dependent)				
e. Heart conditions				
f. Immune system disorders				
g. Kidney disease				
h. Liver disease				
i. Mental illness				
j. Organ Transplants				
k. Lung conditions				

8. Do any of the “yes” answers above reflect claims for COBRA continues? If yes, when will COBRA eligibility end?

Yes	No
------------	-----------

Additional comments: