Group Screening Questionnaire

(For Groups with 51+ Employees)

CareFirst
Family of health care plans

Check one or both companies for which application is being sought:

○ CareFirst BlueCross BlueShield
840 First Street, NE, Washington, DC 20065

○ CareFirst BlueChoice, Inc
840 First Street, NE, Washington, DC 20065

A. COMPANY IDENTIFICATION		
Name of Company	Phone	Date
Street Address		
City	State	ZIP
Type of Business	SIC Code	
Broker of Record		
Requested Broker Commission/Producer Services Fees		
Reason for Soliciting Proposals ○ Cost ○ Dissatisfied with Carrier ○ Dissatisfied with Plan(s) ○ Market Check ○ Other _____		
Requested Proposal Due Date		

B. HEALTH RISK ASSESSMENT

1. Serious Medical Conditions—As an employer, are you aware of any eligible employee* or dependent(s) of an employee, including those not enrolling for coverage, who has been diagnosed or treated within the last 12 months for any of the following conditions? Please mark the number of employees/dependents next to the appropriate condition. Include additional details, if available, in the space provided below or on the reverse side of this document. Do not write member specific information.

Number	Condition
	AIDS/ARC or Acquired Immune Deficiency Syndrome
	Autoimmune disorders (lupus, multiple sclerosis, rheumatoid arthritis, etc.)
	Birth abnormalities/birth injuries
	Blood disorders, i.e., hemophilia, etc.
	Cancer/cancerous tumor/skin cancer. If recovered, months in remission within the last 12 months : _____ Type:
	Chest pain/congestive heart failure/coronary artery disease/bypass
	Chronic obstructive lung disease, i.e., emphysema, bronchitis, etc.
	Diabetes—type/treatment:
	Kidney disorders/kidney stones/polycystic kidney disease—dialysis/renal failure
	Liver cirrhosis/liver disorders/pancreas
	Lupus
	Mental nervous disorders/mental illness/depression/substance abuse

* Eligible persons include owners, partners, part-time employees, and full-time employees; COBRA Extendees (former employees covered by your present health care carrier pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985); or former employees covered by a Maryland Continuation of Coverage provision (if applicable); and the eligible family members, if any. 1099 Recipients are not eligible. Seasonal employees are not eligible. Full-time employees are defined as those who work on average at least thirty (30) hours per week. Part-time employees are defined as those who work at least 17.5 hours per week on a regular (not seasonal or temporary) basis for more than six months each year.

B. HEALTH RISK ASSESSMENT	
Number	**Condition**
	Muscular dystrophy
	Paralysis
	Pregnancy due date(s): _____
	Stomach or bowel disorders, i.e., ulcer/Crohn's disease, ulcerative colitis, etc.
	Stroke (cerebral)
	Transplant (done/pending)—liver/kidney/heart/lung
	Tumor/cysts—benign/malignant

2. Within the last 12 months, have any of your employees or their dependents had a large claim (chronic or ongoing medical condition) that has cost or is likely to cost $25,000 or more per year? If yes, please provide a brief description of the diagnosis and treatment for each individual below.

Are you aware of any other serious conditions within the last 12 months, not listed above? Has any employee or dependent of an employee been hospitalized or received medical treatment within the past 12 months? If yes, explain below.

Are there any employees, currently not actively at work or unable to perform their normal work duties due to a disability or work-related injury? If yes, explain below.

Describe or answer any illness/condition related questions from sections B1 and B2 below. If additional space is needed to respond to any question, please provide response on a separate page and attach.

C. CURRENT COVERAGE INFORMATION

Current Carrier

		Individual	Individual & Child(ren)	Individual and Adult	Family	Type of Benefit Plan	Estimated No. of Contracts
Benefit 1	Current Rates					◯ HMO ◯ PPO ◯ Point of Service ◯ Indemnity	
	Renewal Rates						
Benefit 2	Current Rates					◯ HMO ◯ PPO ◯ Point of Service ◯ Indemnity	
	Renewal Rates						
Benefit 3	Current Rates					◯ HMO ◯ PPO ◯ Point of Service ◯ Indemnity	
	Renewal Rates						
Benefit 4	Current Rates					◯ HMO ◯ PPO ◯ Point of Service ◯ Indemnity	
	Renewal Rates						

C. CURRENT COVERAGE INFORMATION (CONTINUED)		
Employer Contribution Information		
○ Fixed Dollar Amount	Employee_____	Dependent Amount_____
○ Uniform Percentage	Employee_____	Dependent Amount_____
○ Other (please explain) _____		

Projected Enrollment	
FTE count	
Total number of eligible employees	
Total number of participating employees	
Number of employees enrolling in spousal coverage/parental coverage/military coverage	
Number of employees opting out of coverage	
Number of COBRA extendees	
Number of former employees covered by a Maryland Continuation of Coverage provision (if applicable)	
Will part-time employees (17.5 hrs/wk) be covered?	○ Yes ○ No
If covering, number of part-time employees	
Number of disabled former employees	
Number of retirees	

D. PRIOR COVERAGE INFORMATION	
1. Does the Company currently have any coverage with CareFirst and/or CareFirst BlueChoice, Inc. or has the Company had any CareFirst and/or CareFirst BlueChoice, Inc. coverage in the last 18 months?	○ Yes ○ No
If yes, A) Has the Company's CareFirst and/or CareFirst BlueChoice, Inc. been cancelled within the last 18 months?	○ Yes ○ No
B) Please list the prior/current Group number(s):_____.	
Any outstanding balances owed by the Company to CareFirst and/or CareFirst BlueChoice, Inc. must be reconciled before the Company will be approved for group coverage.	

2. Current Carrier	Date coverage began with Current Carrier

Please provide the prior carrier history for the past 5 years		
Carrier Name	From	To
Carrier Name	From	To
Carrier Name	From	To
Carrier Name	From	To

3. Has the Company's coverage been cancelled (or is it in the process of being cancelled) by the Company's present health care carrier?	○ Yes ○ No
4. Has the company filed for bankruptcy (or is in the process of filing for bankruptcy) within the last three (3) years?	○ Yes ○ No

D. PRIOR COVERAGE INFORMATION
If yes, to 3 or 4 please explain:

E. REVIEW AND SIGNATURE	
It is hereby understood and agreed that: The information provided herein is complete and correct to the best of my knowledge and belief. **WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.**	
Please check your role for the Group: ◯ Group Administrator/Representative ◯ Broker	
Signature	Printed Name
Title	Date

CareFirst BlueCross BlueShield offers PPO and traditional indemnity products. CareFirst BlueChoice, Inc. offers HMO products. BlueChoice Opt-Out Plus Open Access is a jointly offered point-of-service product with in-network benefits provided by CareFirst BlueChoice and out-of-network benefits provided by CareFirst, and the Member may choose each time that services are sought to qualify for HMO benefits or traditional indemnity benefits. Point-of-Enrollment is a jointly offered product from CareFirst and CareFirst BlueChoice, in which the Subscriber selects for himself/herself and his/her Dependents a CareFirst or a CareFirst BlueChoice product offered by the Group each year.

CareFirst BlueCross BlueShield is the shared business name of CareFirst of Maryland, Inc. located at 10455 Mill Run Circle, Owings Mills, MD 21117, and Group Hospitalization and Medical Services, Inc. located at 840 First Street, NE, Washington, DC 20065, which are Not-for-Profit Health Service Plans. CareFirst BlueCross BlueShield Medicare Advantage is the shared business name of CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., and CareFirst Advantage DSNP, Inc. CareFirst BlueCross BlueShield Community Health Plan Maryland is the business name of CareFirst Community Partners, Inc. CareFirst BlueCross BlueShield Community Health Plan District of Columbia is the business name of Trusted Health Plan (District of Columbia), Inc. In the District of Columbia and Maryland, CareFirst MedPlus is the business name of First Care, Inc. In Virginia, CareFirst MedPlus is the business name of First Care, Inc. of Maryland (used in VA by: First Care, Inc.).

CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst Advantage, Inc., CareFirst Advantage PPO, Inc., CareFirst Advantage DSNP, Inc., CareFirst Community Partners, Inc., Trusted Health Plan (District of Columbia), Inc., CareFirst BlueChoice, Inc., First Care, Inc., and The Dental Network, Inc. are independent licensees of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.