

This Questionnaire is designed to assist Coventry Health Care, Inc. in obtaining information necessary to evaluate your group.

Firm Name	Business Phone
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Nature of Business	No. of Years in Business
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1. Has Group been previously insured by Coventry Health Care, Inc. or Principal Mutual Life Insurance Company?

List insurance Carriers/HMO Arrangements for the past 5 years.

Name of Carrier/HMO	Type(s) of Coverage	Period Insured
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is any coverage continuing with your carrier/HMO? Yes No
If yes, what type(s) of coverage? _____

2. Please indicate your current and renewal health rates below and attach a copy of your renewal bill or notice.
 Current Rates: Employee \$ _____ Dependent \$ _____ Effective Date _____
 Renewal Rates: Employee \$ _____ Dependent \$ _____ Effective Date _____

3. Please answer the following questions to the best of your knowledge. Note: Please do not disclose the name of any employee or dependent. Include any individual currently insured with your present plan under COBRA or State continuance provisions. Give details to questions answered "yes." Please use the reverse side if more space is needed.

	Yes	No
a. Are you aware of any of your employees or dependents with a medical problem or with a history of frequent or recent medical treatment? (e.g. cancer, diabetes, cardiovascular disease, substance abuse, mental illness, pregnancy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you aware of any employee or dependent who has hospitalization, surgery or treatment pending or that has been advised that hospitalization, surgery or treatment is needed?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you aware of any employee or dependent who would be applying for coverage that is disabled or has a mental or physical disorder?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you aware of any employee or dependent who has Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or immune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
e. Has any employee been absent for 10 or more consecutive days in the past 12 months due to an illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>
f. Are you aware of any employee who is not actively at work or a dependent who is home or hospital confined?	<input type="checkbox"/>	<input type="checkbox"/>
g. Are there any dependent children age 19 and over who might be considered developmentally disabled or physically handicapped?	<input type="checkbox"/>	<input type="checkbox"/>
h. Please list any claims that you are aware of that have exceeded \$5,000 in the last 12 months on any employee or dependent. Please provide an estimate of the approximate amount paid, medical condition, and the likelihood of future expenses. _____		

I hereby certify that to the best of my knowledge the above information is complete and true. I understand that this is not an application for coverage. Any group insurance coverage will not be made effective until a proposal is made to the group, application is made by the group to Coventry Health Care, Inc. and any information given on this form, the application form, or discovered independently is evaluated by Coventry Health Care and coverage is approved at its Corporate Office in Bethesda, Maryland.

Prospective Applicant Signature	Title	Date
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Plan to Complete:

Reviewer	Date Called Corporate Office	
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Corporate Office to Complete:

Reviewer	Date	Accept <input type="checkbox"/>	Decline <input type="checkbox"/>
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