

Check box of the appropriate Plan:
 Optimum Choice, Inc.®
 4 Taft Court
 Rockville, MD 20850
 MAMSI Life & Health Insurance Company
 4 Taft Court
 Rockville, MD 20850



GROUP RISK ASSESSMENT

Application is hereby made for group coverage for eligible employees and their eligible dependents based on the following information:

Products: Check applicable boxes: Health Insurance Life Insurance
 Dental Insurance Short Term Disability

Company Name: _____ SIC Code _____
 Address: _____
 City: _____ State: _____ Zip Code: _____ Telephone: _____
 Company Official: _____ Title: _____
 Person to Contact: _____ Title: _____
 Nature of Business: _____
 Total No. of Employees: _____ Full-time: _____ Part-time: _____ Union: _____
 Total number of eligible employees: _____ Number enrolled: _____

1. How long have you been with your current carrier? ___ years
2. Do you have any subsidiaries? _____ YES NO
3. Does your company offer coverage to subcontractors (1099's)? If yes, how many are covered? _____
4. Number of employees regularly scheduled to work at least thirty (30) hours per week _____ .
5. Full-time is defined to be employees working a minimum of _____ hours per week on a regular year-round basis.
6. Total number of all employees _____ .
7. Average number of eligible employees for the past two years: _____ .
8. Are union employees covered by another plan? YES NO
9. Are 50%, or more, of your employees family members? YES NO

What is the average age of the enrolled employees? _____ Requested effective date: _____

10. Are all eligible employees actively at work? YES NO
11. Do you have any employees age 65 or over actively at work? YES NO

NOTE: Verification of employment/number of hours is required for all employees age 65 or over.

COMPANY WAITING PERIOD: _____
(This is the amount of time an employee must be employed before being eligible for benefits.)

Employer premium contribution to: Employee coverage: _____ %; Dependent coverage: _____ %
NOTE: It is agreed that if the employer pays the entire cost of the coverage, 100% of the eligible employees must be covered. The employer agrees to make monthly payroll deductions for the employee contributions, if any, for each employee enrolling in the benefit program.

12. Are there any current or prior employees or dependents covered under COBRA? YES NO
 If YES, how many? _____ (Please indicate on employee application)
13. Do you have any employees or any knowledge of employees' dependents who live out of the area and who require coverage? YES NO
 If YES, number of employees or dependents and where they are located: _____

14. Has your group been declined for any group insurance coverage in the past 2 years? YES NO
 If YES, reasons: _____

Please Answer The Following to the Best of Your Knowledge:

Are you aware of any employees or dependents (including individuals covered under COBRA) that:

1. Are currently disabled? If YES, please complete the following: YES NO
Workman's Compensation _____ Short Term Disability _____ Long Term Disability _____
(Circle Status) Condition or injury: Expected Return to Work Date:
W/C STD LTD _____
W/C STD LTD _____
2. Had any claims paid in the 12 (twelve) months equal to or greater than \$5,000? If YES, please show amount and describe the condition below. If additional space is needed, please attach a separate sheet YES NO

3. Have a Medical condition of life threatening conditions other than stated elsewhere on this form? YES NO
If "YES", please indicate condition: _____
4. Are scheduled or advised to be hospitalized and/or have surgery? If YES, please describe the condition including age, treatment, medication and prognosis, if known: YES NO

5. Are currently pregnant? If YES, how many: _____ YES NO
Expected delivery date (s) _____
Any current or anticipated complications? If YES, please give details, if known: YES NO

6. Might be considered developmentally disabled or physically handicapped or have a birth defect? YES NO
Is this the result of an accident or as a result of their birth? Accident Birth
Are they receiving any treatment or require any specialized medical services? YES NO
If YES, please describe: Include age, condition and any treatment or medical services being utilized, if known:

7. Have a mental illness or any mental health condition for which they have been told to seek treatment or for which they are receiving or have received any form of treatment? YES NO
If YES, please describe the condition including, age, treatment, medication and prognosis:

8. Have any drug/alcohol problems or have received or expect to receive any treatment related to drugs/alcohol including but not limited to: Marijuana, cocaine, heroin, amphetamines (speed), barbiturates (downers) or have abused any prescription drugs? If "YES", please describe: YES NO

The statements herein are represented to be true and complete to the best of the company's knowledge and belief and it is acknowledged that such statements of the employer will be relied upon in the assessment of risk. This is not a contract. Completion of this application does not constitute any obligation on either party's behalf. Should the undersigned Employer fail to qualify as an eligible Employer, any monies paid by or on account of the undersigned for the purposes specified above shall be returned, to the extent unexpended and there shall be no further obligation on the part of either party.

We understand that Optimum Choice, Inc. and MAMSI Life and Health Insurance Company will use summary or other health information maintained by any health insurance, life insurance, disability or other insurance carrier or product affiliated with Optimum Choice, Inc. and MAMSI Life and Health Insurance Company in connection with determining whether to offer any of the insurance products identified in this Application.

Date _____ Employer Signature _____