

Select Risk Screening Questionnaire

(This form is not an application for insurance)

Name of Company _____ Phone _____ Date _____
 Location _____

Street _____ City _____ State _____ Zip Code _____
 Type of Business _____ SIC Code _____

Number of full-time Employees actively at work _____ Expected Enrollment _____
 Number of COBRA Extendees _____ Number of Disabled Employees _____
 Eligible Part-time Employees (20 hrs/wk) _____ Number of Retirees under 65 _____

Health Risk Assessment

1. To the best of your information and belief, indicate beside each condition the number of eligible persons to be covered who have been treated, are currently being treated or are expected to be treated for a condition or serious illness such as the following:

<p>_____ AIDS/HIV+</p> <p>_____ Cancer</p> <p>_____ Chronic Heart, Kidney or Liver Disease</p> <p>_____ Existing Pregnancy</p> <p>_____ Psychiatric Disorders</p>	<p>_____ Birth Defects or Disorders</p> <p>_____ Substance Abuse</p> <p>List other conditions or illnesses _____</p> <p>_____</p>
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2. To the best of your information and belief, is there any eligible person who has incurred \$10,000 or more in medical expenses in the last 12 months or who is expected to be hospitalized for a serious medical condition. _____ Yes _____ No

3. To the best of your information and belief, is there any eligible person to be enrolled for group coverage who has been denied coverage by your current or last health care carrier? _____ Yes _____ No

4. Has the company changed health care carriers three (3) times in the past five (5) years? _____ Yes _____ No

5. Has the company's coverage been cancelled or is in the process of being cancelled by the company's current carrier? _____ Yes _____ No

6. Has the company filed for or in the process of filing for bankruptcy? _____ Yes _____ No

It is hereby understood and agreed that:

The information provided herein is complete and correct to the best of my information and belief and has been provided for purpose of obtaining health insurance coverage. In the event the information provided herein is not complete and correct, CareFirst BlueCross BlueShield (CareFirst) and CareFirst BlueChoice, Inc. reserve the right to limit and recover any losses by pursuing all available legal remedies including but not limited to the following: the contract may be cancelled immediately by CareFirst and CareFirst BlueChoice, Inc. and CareFirst and CareFirst BlueChoice, Inc. shall have no further liability hereunder; and any conversion privileges provided pursuant to the contract shall be null and void.

Company: _____ By: _____
Signature of Company Officer

Title: _____ Date: _____

Representatives' Review and Signature: _____

Broker: _____ CareFirst / CareFirst BlueChoice, Inc.: _____

By: _____ By: _____

Title: _____ Title: _____

Date: _____ Date: _____