Employer Questionnaire
Ohio

Anthem BlueCross BlueShield

Section 1: Employer information

Employer name		Business phone no.	Federal tax ID no.	Years in business
Street address	City	County	State	ZIP code
Type of business	Name of any affiliate companies/subsidiaries	Email address		

Section 2: Prior medical coverage — Describe all medical plans offered during the last five years.

Carrier name	Type of coverage (PPO, HMO, Indemnity, deductibles/copays)	Period in effect
1.		
2.		
3.		
Please furnish a copy of your last billing statement and current benefit summary, along with this form.		

Section 3: Eligibility and participation

State company is headquartered in	Is your company part of a PEO/Employee Leasing Arrangement, Healthcare Alliance, or Association? ☐ Yes ☐ No If yes, who? _____
No. of **eligible** employees working a minimum of 30 hours: _____	No. of **ineligible** employees (part-time, seasonal): _____
Total no. of employees (includes all payroll employees other than a 1099): _____	
Total no. of employees **enrolled** in the medical plan: _____	Are all of these employees W-2? ☐ Yes ☐ No

Section 4: Out-of-state residents

Do any employees reside outside the Ohio service area? ☐ Yes ☐ No If yes, list state and/or ZIP code and the number of employees that reside in each state.

City, state/ZIP code	No. of employees residing there	City, state/ZIP code	No. of employees residing there
1.		4.	
2.		5.	
3.		6.	

Section 5: Additional information

What other lines of coverage are currently offered to your employees? ☐ Dental ☐ Vision ☐ Life

Employer contribution level: Single coverage: _____ Dependent coverage: _____

List below, any members participating in the medical plan who have incurred medical expenses in excess of $10,000 in the last 18 months.

Name	Employee, spouse or dependent	Diagnosis	Claim amount	Status
1.	☐ Employee ☐ Spouse ☐ Dep			
2.	☐ Employee ☐ Spouse ☐ Dep			
3.	☐ Employee ☐ Spouse ☐ Dep			

COBRA: List below, anyone currently eligible or enrolled in COBRA.

Name	Date of qualifying event	Expiration date	Qualifying event
1.			
2.			
3.			

Retirees: List below, anyone currently enrolled in the plan as a retiree.

Name	Age at retirement	Date of retirement	Percent of employer contribution
1.			
2.			
3.			

List below, any employees that have been absent from work for five or more consecutive days due to illness or injury in the last 12 months.

Name	Period of time absent	Reason
1.		
2.		
3.		

Section 6: Rate history

Fully Insured	Prior year rates	Current rates	Renewal rates
Single			
Employee & Spouse			
Employee & Child			
Family			

Self Funded	Prior year rates	Current rates	Renewal rates
Administrative Fee			
Specific Premium			
Aggregate Premium			
Aggregate Attachment Point			

Section 7: Medical information

1. Please answer the following questions to the best of your knowledge for the persons eligible for medical insurance (including dependents). Please provide details on a separate sheet of paper.
   - A. Has anyone been treated for a serious illness, been hospitalized or had surgery during the past 12 months? ☐ Yes ☐ No
   - B. Is anyone expected to have a continuing claim for an existing mental or physical disorder? ☐ Yes ☐ No
   - C. Are there any employees who, because of illness or injury, are not actively at work performing their normal duties on a full-time basis? ☐ Yes ☐ No
   - D. Are there any spouses or dependents who, because of illness or injury, are not either actively at work or not performing age appropriate activities of daily living? ☐ Yes ☐ No

2. Check the following boxes for any known medical conditions in your group:

☐ AIDS, HIV+
☐ Alzheimer's
☐ Aneurysm Type: _____
☐ Rheumatoid arthritis
☐ Back/spine injuries Type: _____
☐ Cancer present (within 12 mos) Type: _____
  ☐ Recovered 1-2 yrs. Type: _____
  ☐ Recovered 3-5 yrs. Type: _____
☐ Cerebral palsy
☐ Circulatory: Coronary artery disease (within 5 yrs)
☐ Circulatory: Heart attack
  ☐ Operated ☐ Unoperated
☐ Chronic obstructive pulmonary disease (COPD)
☐ Crohn's disease
☐ Cystic fibrosis
☐ Diabetes
  ☐ Diet controlled ☐ Insulin - Adult onset
  ☐ Oral medications ☐ Insulin - Child onset
☐ Emphysema
☐ Epilepsy
☐ Hemophilia
☐ Is anyone currently taking injectable medication that is not for diabetes or allergies? If so, what kind: _____
☐ Kidney dialysis/Renal failure
  Is member Medicare Primary? ☐ Yes ☐ No
  If no, effective date member become Medicare Primary? _____
☐ Liver (Cirrhosis)
☐ Liver (Hepatitis non-alcoholic)
☐ Lupus/Connective tissue disease
☐ Lyme's/Parasitic disease
☐ Lymphoma/Leukemia
☐ Mental health disorder
  ☐ Schizophrenic disorders ☐ Depressive disorders ☐ Anxiety disorders
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Pancreatitis
☐ Paralysis
☐ Pregnancy (provide due date): _____
☐ Spina bifida
☐ Stroke (within 5 yrs.)
☐ Substance abuse (within 5 yrs.)
☐ Transplant
  Needed: Type & date will be completed: _____
  Done: Type & date completed: _____
☐ Ulcerative colitis
☐ Other (list condition(s) below)
_____
_____

3. Is there any additional information that you think will assist Anthem Blue Cross and Blue Shield (Anthem) in assessing the medical condition(s) present in your group? If so, please provide in the space below:

_____

_____

_____

Section 8: Signatures required

The prospective applicant hereby certifies that the above information is complete and true to the best of his or her knowledge. Any person who, with the intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Employer representative's signature **X**	Date
Printed name of employer representative	Title of employer representative
Sales representative signature **X**	Broker signature **X**