

# Employer Questionnaire



## Blue Shield of California and Blue Shield of California Life & Health Insurance Company

### For 15 to 50 enrolling employees

Please fax back to: \_\_\_\_\_

**For UW use only:**

Group name: \_\_\_\_\_

Probable RAF \_\_\_\_\_ Date \_\_\_\_\_ UW \_\_\_\_\_

Proposed effective date: \_\_\_\_\_

Final RAF \_\_\_\_\_ Date \_\_\_\_\_ UW \_\_\_\_\_

Has the group been covered by Blue Shield in the past 12 months?  Yes  No

Type of business (SIC): \_\_\_\_\_

County location: \_\_\_\_\_

What percent of the health coverage cost is paid by the employer? For employees: \_\_\_\_\_ % For dependent: \_\_\_\_\_ %

**Complete the following questions for your employees and their dependents including those with COBRA/ CalCOBRA. Please respond to the best of your knowledge – you are not required to obtain information from employees.**

**Notice:** Information provided by the employer on this form is relied upon by Blue Shield to provide a probable Risk Adjustment Factor (RAF) and quote to the group. In addition, Blue Shield may review prior Blue Shield claims history. Acceptance of a quote constitutes only a preliminary agreement between the parties. Blue Shield reserves the right to adjust the proposed RAF and rates based on actual enrollment in order to execute a definitive agreement.

		Yes	No
<b>1</b>	Employee eligibility Total number of employees _____ (excluding COBRA/CalCOBRA) Number of COBRA/CalCOBRA participants _____ Number of participating employees _____		
	Number of ineligible employees _____ Number of full-time employees _____ Number of participating dependents _____		
<b>2</b>	Is any person to be covered unable to work due to injury or illness?	<input type="checkbox"/>	<input type="checkbox"/>
<b>3</b>	Is any person unable to perform the normal duties in their customary employment or activity?	<input type="checkbox"/>	<input type="checkbox"/>
<b>4</b>	Are any dependent children incapable of self-support because of physical or mental disability?	<input type="checkbox"/>	<input type="checkbox"/>
<b>5</b>	Is any person currently hospitalized or been told extensive medical treatment, surgery, or hospitalization is required?	<input type="checkbox"/>	<input type="checkbox"/>
<b>6</b>	Is any person being treated for heart disease, stroke, cancer, kidney disorder, AIDS, AIDS-related complex, chronic respiratory disease, or other serious condition?	<input type="checkbox"/>	<input type="checkbox"/>
<b>7</b>	Has any person suffered a condition that resulted in expenses of \$5,000 or more, or been hospitalized during the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
<b>8</b>	Is there any person being treated for alcoholism or chemical dependency or been advised to seek treatment?	<input type="checkbox"/>	<input type="checkbox"/>
<b>9</b>	Is any person currently pregnant? If yes, how many? _____ Due date(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
<b>10</b>	Are any persons included who are not employees for the purpose of workers' compensation law or similar legislation? If yes, provide name and title.	<input type="checkbox"/>	<input type="checkbox"/>
<b>11</b>	Do you have COBRA/CalCOBRA applicants? Please indicate date of qualifying event and reason.	<input type="checkbox"/>	<input type="checkbox"/>
<b>12</b>	Are any participants not subject to W-2 withholding? If yes, please explain.	<input type="checkbox"/>	<input type="checkbox"/>
<b>13</b>	What company provides your current health coverage?	<input type="checkbox"/>	<input type="checkbox"/>
<b>14</b>	Do you want a Dual Option, Suite Deal, or PlanSelect quote? If yes, list Plan _____	<input type="checkbox"/>	<input type="checkbox"/>

**For each question answered yes, please provide additional information page 2.**

(continued on page 2)

