EMPLOYER HEALTH QUESTIONNAIRE (FOR 25+ ENROLLING EMPLOYEES)

Please answer the following questions to the best of your knowledge for your employees and/or dependents, including any COBRA participants.

1)	Is there any employee, dependent of an employee, or person who will be covered under this plan who has received in excess of $5,000 in medical care expenses in the last 2 years?	☐ Yes ☐ No
2)	Is there any employee, dependent of an employee, or person to be covered under this plan who is unable to work or attend school due to an injury or illness?	☐ Yes ☐ No
3)	Are there any employees, dependents of employees, or person(s) to be covered under this plan who are currently pregnant?	☐ Yes ☐ No
4)	Are there any dependent children incapable of self support because of a physical or mental disability?	☐ Yes ☐ No
5)	Are there any employees, dependents of an employee, or person(s) to be covered under this plan being treated or been hospitalized for any of the following: heart disease, kidney disorder, stroke, cancer, AIDS, AIDS Related Complex (ARC), diabetes, respiratory diseases, or any mental or nervous conditions?	☐ Yes ☐ No

FOR EACH QUESTION ANSWERED "YES", PLEASE EXPLAIN TO THE BEST OF YOUR ABILITY:

QUESTION # _____

QUESTION # _____

QUESTION # _____

QUESTION # _____

NOTE – The final RAF is based upon Sharp Health Plan and Allied National review of the information submitted.

I agree: That all the information in this questionnaire is correct and true to the best of my knowledge.
I understand that California law prohibits an HIV test from being required or used by health care plans as a condition of obtaining coverage. I, the applicant, acknowledge that I have read and understand this questionnaire in its entirety

X Signature of Company Officer/Owner	Print Name/Title/e-mail address	Date

BROKER / GENERAL AGENCY INFORMATION	
Broker Name / Agency Name:	Tax ID:
General Agency Name *(if applicable):*	License: Exp.
Address: City/State/Zip:	Phone: Fax: E-mail:

X Broker/Agent Signature	Broker/Agent Name (Print)	Date