



**GROUP SCREENING QUESTIONNAIRE
FOR BUSINESSES HEADQUARTERED IN VA AND DC
(For Groups with 25+ Enrollees)**



A. Company Identification:

Name of Company: _____ Phone: _____ Date: _____

Location: _____
Street City State Zip Code

Type of Business: _____ SIC Code: _____

Number of full-time Employees actively at work: _____
 Number of COBRA Extendees*: _____
If eligible, number of Part-Time Employees (17.5 hrs/wk): _____
 Expected enrollment: CareFirst BlueChoice _____
 CareFirst BlueCross BlueShield _____

Non-Eligible Persons:
 Number of Disabled former Employees: _____
 Number of Retirees: _____
 Number of Part-Time Employees working; less than 17.5 hrs/wk: _____; 17.5 or more hrs/wk: _____

B. Enrollment Requirements:

It is understood and agreed that in order to be eligible for coverage and maintain such eligibility, the Group must meet the following requirements:

- To be eligible for CareFirst BlueCross BlueShield (CareFirst) and/or CareFirst BlueChoice, Inc. Group Coverage, the employer must contribute an amount equal to at least 50% of the cost of the Self-Only Coverage for enrolled employees.
- **75%** of all employees eligible for coverage (or 100% if the employer pays the entire Self-Only premium) after first subtracting
 - those employees who have coverage under their spouse's or parent's group coverage, CHAMPUS, Medicare as primary under TEFRA, or their prior employer's plan under COBRA or Maryland Extension of Coverage Law, and
 - those employees enrolled in other CareFirst or CareFirst BlueChoice, Inc. coverage; OR
- Groups with CareFirst BlueChoice HMO must enroll at least five Eligible Employees.
- The Group cannot enroll in their HMO programs (other than CareFirst BlueChoice, Inc.) more than **25%** of the total number of employees enrolled in all health programs offered through the Group.
- At least two employees must be employed full-time and enrolled under the Group's coverage at all times. (NOTE: Those employees with complementary to Medicare coverage do not count toward the two-employee minimum enrollment requirement.)
- Enrolled groups that drop to less than two full-time employees should contact their CareFirst or CareFirst BlueChoice, Inc. Account Manager to arrange for individual direct pay coverage.

Point-of-Sale Minimum Enrollment Requirements: The Group must enroll and maintain enrollment (unless otherwise approved by CareFirst/CareFirst BlueChoice, Inc.) of:

- **100%** of all employees eligible for coverage after first subtracting
 - those employees who have coverage under their spouse's or parent's group coverage, CHAMPUS, Medicare as primary under TEFRA, or their prior employer's plan under COBRA or Maryland Extension of Coverage Law,
 - those enrolled in other CareFirst or CareFirst BlueChoice, Inc. coverage, and
 - those employees enrolled in a staff model HMO.
- The Group cannot continue to enroll new employees in their staff model HMO.
- At least two employees must be employed full-time and enrolled under the Group's coverage at all times. (NOTE: Those employees with complementary to Medicare coverage do not count toward the two-employee minimum enrollment requirement.)
- Enrolled groups that drop to less than two full-time employees should contact their CareFirst or CareFirst BlueChoice, Inc. Account Manager to arrange for individual direct pay coverage.

Does the Company agree to comply with both of the following provisions: (1) meet all of the above listed group enrollment requirements by the time it applies for enrollment with CareFirst BlueChoice, Inc. and/or CareFirst and (2) will the Company continue to meet such requirements while such coverage is in effect? Yes No

C. Health Risk Assessment:

1. To the best of your information and belief, indicate beside each condition the total 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, but not limited to:

- | | |
|---|---|
| <input type="checkbox"/> AIDS; HIV+ (Positive HIV Test); | <input type="checkbox"/> Psychiatric Disorders; |
| <input type="checkbox"/> Cancer; | <input type="checkbox"/> Significant Congenital (Birth) Defects or Disorders; |
| <input type="checkbox"/> Central Nervous System Diseases; | <input type="checkbox"/> Substance Abuse; |
| <input type="checkbox"/> Chronic Heart, Kidney, or Liver Disease; | <input type="checkbox"/> Other (List): <u>Number</u> <u>Condition/Illness</u> |
| <input type="checkbox"/> Existing Pregnancy Only; | _____ |
| | _____ |
| | _____ |

2. To the best of your information and belief, is there any eligible person who has incurred \$10,000 or more in medical expenses over the past 12 calendar months, or who is expected to incur \$10,000 or more in medical expenses over the next 12 calendar months? Yes No
 If YES, please provide a brief description of the diagnosis and treatment for each individual

*Eligible persons include owners, partners, and employees, actively at work and working at least 30 hours per week; COBRA Extendees (former employees covered by your present health care carrier pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985); and the eligible family members, if any, who on the effective date of their coverage are not confined to a health care facility or not confined to home due to accident or illness. 1099 Recipients are not eligible. Retirees and seasonal employees, and disabled former employees are not eligible.

PLEASE COMPLETE AND SIGN THE BACK OF THIS QUESTIONNAIRE.

D. Current Coverage Information:

| | Self-Only (use Age 40, if Age Rated) | Two Party | Family (use Age 40, if Age Rated) | Effective Date of these Rates | Type of Benefit Plan | Estimated No. of Contracts |
|------------------------|---|-----------|--------------------------------------|-------------------------------|---|----------------------------|
| Insurance Carrier No 1 | Name _____ | | | | <input type="checkbox"/> HMO | _____ |
| Previous Rates: | \$ _____ | \$ _____ | \$ _____ | _____ | <input type="checkbox"/> Point of Service | _____ |
| Current/Renewal Rates: | \$ _____ | \$ _____ | \$ _____ | _____ | <input type="checkbox"/> PPO | _____ |
| | | | | | <input type="checkbox"/> Indemnity | _____ |

E. Prior Coverage Information:

- Has the Company's coverage with CareFirst and/or CareFirst BlueChoice, Inc. been cancelled within the last 18 calendar months? **Yes** **No**
 If so, please list the prior Group Number: _____
 Any outstanding balances owed by the Company to CareFirst and/or CareFirst BlueChoice, Inc. must be reconciled before the Company will be approved for group coverage.
- Has the Company changed health care carriers three (3) or more times in the past five (5) years? **Yes** **No**
 If so, please list carriers: _____

- Has the Company's coverage been cancelled (or is it in the process of being cancelled) by the Company's present health care carrier? If yes, please explain: _____ **Yes** **No**

F. Employer Contribution Information:

- Uniform percentage for each carrier's plan.
- Fixed dollar amount regardless of plan-Dollar amount: Individual \$ _____ Family \$ _____
- Other (Please explain): _____

G. Company Certification:

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 to cause the issuance of an application and, upon approval by CareFirst BlueChoice Inc., and/or CareFirst to become a part of the group contract applied for. In the event the information provided herein is not complete and correct to the best of my information and belief, then CareFirst BlueChoice Inc., and/or CareFirst reserves 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 BlueChoice Inc., and/or CareFirst and it shall have no further liability hereunder; and any conversion privileges provided pursuant to the contract shall be null and void.
- CareFirst BlueChoice Inc., and/or CareFirst must review this screening questionnaire before coverage may be offered.

COMPANY:

By: _____
 Signature of Company Officer

Title: _____ Date: _____

H. Representatives' Review and Signature:

BROKER: CAREFIRST BLUECHOICE, INC. or CAREFIRST BLUECROSS BLUESHIELD

By: _____ By: _____

Title: _____ Title: _____

Date: _____ Date: _____