



Group Hospitalization and Medical Services, Inc.  
 840 First Street, NE  
 Washington, DC 20065

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 Washington, DC 20065

### Select Risk Screening Questionnaire

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

- 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:  
 \_\_\_\_\_ AIDS/HIV+ \_\_\_\_\_ Birth Defects or Disorders  
 \_\_\_\_\_ Cancer \_\_\_\_\_ Substance Abuse  
 \_\_\_\_\_ Chronic Heart, Kidney or Liver Disease \_\_\_\_\_ List other conditions or illnesses  
 \_\_\_\_\_ Existing Pregnancy \_\_\_\_\_  
 \_\_\_\_\_ Psychiatric Disorders \_\_\_\_\_
- 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
- 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
- Has the company changed health care carriers three (3) times in the past five (5) years? \_\_\_\_\_ Yes \_\_\_\_\_ No
- Has the company's coverage been cancelled or is in the process of being cancelled by the company's current carrier? \_\_\_\_\_ Yes \_\_\_\_\_ No
- 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.

Company: \_\_\_\_\_ By: \_\_\_\_\_  
 Signature of Company Officer

Title: \_\_\_\_\_ Date: \_\_\_\_\_

Representatives' Review and Signature: \_\_\_\_\_

Broker: \_\_\_\_\_ CareFirst / CareFirst BlueChoice, Inc.: \_\_\_\_\_

By: \_\_\_\_\_ By: \_\_\_\_\_

Title: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_

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