

Clear Advantage 51-125 — Employer Risk Evaluation Questionnaire



Employer Information

Employer name: _____ Effective date: _____

Address: _____

Type of business: _____ How long in business: _____ SIC code: _____

Eligibility Information

Total # of employees: _____	<p>Eligible employees are permanent, active, full-time employees working a minimum of 30 hours per week, excluding COBRA participants.</p> <p>Ineligible classes include: retirees, 1099 employees, part-time working less than 30 hours per week, leased employees, seasonal employees, board members, surviving spouse.</p>
Total # of eligible employees: _____	
Total # of eligible enrolled: _____	
Total # of enrolled COBRA (maximum 7%): _____	
Total # covered by Kaiser: _____	
Total # covered by spouse plan: _____	

Employer contribution (minimum 75% for employee or 50% combined employee and dependents)	Employee:	Dependents:
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Please answer the following questions to the best of your knowledge for the persons to be insured (employees, dependents, proprietors, partners).

1. Has group been insured by Health Net within the past 24 months? Yes No

2. In the most recent 12 months, has enrollment or eligible lives fluctuated more than 20%? Yes No
Do you anticipate fluctuation over 20% during the following 12 months?

3. Has any insured received medical benefits in excess of \$25,000 in the last 12 months? Yes No

4. Are there any catastrophic or other serious medical conditions, disabilities, pregnancies or coverage of members not actively-at-work or currently hospital-confined? Yes No

5. Are all employees covered by workers' compensation insurance? Yes No

6. Will Health Net be offered as sole carrier? (If not, Kaiser is the only allowable exception) Yes No

7. Has any owner or principal filed bankruptcy within the past seven years, or is known to be planning to file bankruptcy, either personally or on behalf of the company applying for coverage? Yes No

Please provide details below for any "yes" responses for questions 1-4 and 7 or "no" responses to questions 5 and 6. If additional space is required, please submit on a separate sheet of paper.

Carrier History (most recent five years)

Carrier name	Type of coverage	Period insured

Health Net will rely on the information provided to determine whether a proposal will be valid. The responses are assumed to be correct. If errors or omissions are subsequently found, Health Net reserves the right to revise rates or rescind the quote.

_____ Signature of Human Resources Manager	_____ Name of Firm	_____ Date
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_____ Signature of Broker/Consultant	_____ Name of Firm	_____ Date
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