ConnectiCare

PRINT IN INK - COMPLETE BOTH PAGES OF FORM			
Legal name of group:			
D/B/A:			
Address: Street:			
City/State/Zip			
Type of business:	SIC code:	#Years in business:	Requested effective date:

Answer the following questions, to the best of your knowledge, for ALL eligible employees and dependents.
Your answers must include all COBRA, state continued individuals, and employees on STD or LTD.
PLEASE DO NOT CONTACT EMPLOYEES TO ANSWER THESE QUESTIONS. PLEASE REFER TO YOUR RECORDS.

		YES	NO
1	Have any employees/dependents incurred medical or hospital expenses of $10,000 or more in the past 2 years?		
2	Are any employees/dependents currently covered due to: **A.** COBRA/state continuance **B.** extension of benefits **C.** short or long term disability (STD or LTD)		
3	Are there any employees currently unable to perform his or her duties full time, and/or have missed 10 or more consecutive days of work due to illness, injury, mental, or physical disability?		
4	In the past 5 years, have any employees/dependents been diagnosed or treated for heart disease, high blood pressure, stroke, diabetes, seizure, kidney disease, back disorders, chronic lung disorders, cancer, tumors, congenital disorders, liver disease, alcohol or drug abuse, mental or nervous conditions, multiple sclerosis or AIDS, ARC, HIV infection?		
5	Will any employee/dependent be having a continued claim due to an existing mental or physical disability or for prescription drugs, such as those used for immune deficiencies, anti-rejection, growth or cardiac disorders?		
6	Have any employees/dependents been advised to undergo medical treatment, surgical operations, diagnostic testing, or hospitalization in the next 6 months?		
7	Has any employee/dependent been advised they are in need of an organ transplant?		
8	Have any employees requested, but not started, STD or LTD?		
9	Are any employees/dependents, whether or not applying for coverage, currently pregnant?		
10	Have any employees/dependents had complications of pregnancy such as toxemia or fetal abnormalities?		

PAGE 2 MUST BE COMPLETED AND SIGNED

If you answered "yes" to any of the previous questions,
please provide the requested information for each individual: (Additional pages may be submitted)

Additional information for questions 1-10

Diagnosis	Age	Dollar amount of Claim and/or length of stay	Current Condition	Date	Related Information

COBRA and/or STD-LTD Information:

Reason for Continuance or Disability	Age	Health Condition	Date Continuance or Disability will end

I represent, to the best of my knowledge, that the information I have furnished on this statement is accurate and complete. I understand that any material omissions, misrepresentations, or misstatements of information requested may result in rescission (i.e. retroactive termination) of coverage(s) or adjustment to rates.

_____ _____

Employer/Group Name (please print) Date

_____ _____

Signature - Owner or Officer of Firm Title

_____

Name of Owner or Officer (please print)