

## Group Risk Questionnaire

**Please explain any “Yes” answers to questions 1 through 8 in the DETAILS TABLE below.**

|   |  |
|---|--|
| 1. Have any of your employees, their dependents, or COBRA participants incurred medical and/or hospital expenses of \$5,000 or more within the last 12 months?  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 2. Are any of your employees, their dependents or COBRA participants currently unable to perform their job duties full time because of illness, injury, mental disorder or physical disability?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 3. Are any of your employees, their dependents or COBRA participants confined at home, in a hospital or other treatment facility?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 4. Are any of your employees, their dependents, or COBRA participants currently undergoing continuing treatment for an illness, injury, mental disorder, or physical disability for which expenses are \$200 per month or \$2,500 per year (including doctor visits, medications, special therapy, etc.)?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 5. Are any of your employees, their dependents, or COBRA participants currently pregnant?<br>If yes, are there any expected complications or risks?<br>What is the expected due date(s)? _____  | <input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. In the past five years have any of your employees, their dependents, or COBRA participants been diagnosed or received treatment or advice from a physician for cancer, heart disease or disorder, lung disease or respiratory disorder, stroke, kidney/urinary disorders, liver disorder, neurological disorders, skin disease diabetes, arthritis back/spine/or joint disorder, brain disorder, AIDS/ARC (AIDS related conditions), other immune system disorder, alcohol/drug or substance abuse, mental health or nervous disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 7. Will any of your employees, their dependents, or COBRA participants require hospitalization or surgery in the next 12 months?  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |
| 8. Have any of your employees, their dependents, or COBRA participants been advised to have a surgical operation, which has not yet been performed?   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |

### DETAILS TABLE:

**Please provide specific details below to any question answered “Yes” above.  
Use page 2 if necessary. An incomplete Details Table may delay your enrollment.**

| Question # | Description of Problem, Condition, Treatment, & Outcome | Medications | Last Date Treated | Still Under Treatment? |
|------------|---|-------------|-------------------|------------------------|
|            |   |             |                   |                        |
|            |   |             |                   |                        |
|            |   |             |                   |                        |
|            |   |             |                   |                        |

I understand that my group’s coverage will not be made effective until all enrollment information given here, or is otherwise provided to, or obtained by Rocky Mountain Health Plans, is evaluated and approved.

I understand Rocky Mountain Health Plans has the right to terminate coverage and deny benefits if any information on this enrollment application, or as otherwise provided by the undersigned for enrollment purposes is false, incomplete or misleading in any material respect.

|                                |   |       |
|--------------------------------|---|-------|
| Employer Authorized Signature: | Title:  | Date: |
| Underwriter Signature:         | Approved/Medical <input type="checkbox"/> Yes <input type="checkbox"/> No | Date: |

