BlueCross BlueShield Nebraska

An independent licensee of the Blue Cross and Blue Shield Association

Employer Risk Appraisal Questionnaire

Blue Cross and Blue Shield of Nebraska (BCBSNE) will use the information you provide in this questionnaire to evaluate your group's risk characteristics to more accurately establish rates, benefits and eligibility rules as part of your application for coverage.

I. GENERAL INFORMATION

Company Name	
Company Address/City/State/Zip	
Phone Number	Requested Effective Date
Nature of Business & SIC	Years in Operation
Reason Out to Bid	

II. HEALTH INFORMATION

Please answer the following questions to the best of your knowledge for all eligible employees, spouses, dependent children, retirees, and COBRA participants. If any of the conditions apply to COBRA participants, please indicate accordingly and provide the beginning and ending COBRA eligibility dates. **For "Yes" answers, please provide the requested information for each individual in the space provided.**

☐ Yes ☐ No 1. Are any eligible employees or dependents receiving disability benefits of any type including Short Term Disability, Long Term Disability, Social Security Disability Income, Workers' Compensation, Medicare or Medicaid, or on extended leave due to injury, disability or illness?

☐ Yes ☐ No 2. Are any eligible employees or dependents contemplating treatment or hospitalization, been advised to seek treatment, or been scheduled for hospitalization and/or surgery?

☐ Yes ☐ No 3. Have any eligible employees or dependents had large claims in excess of $10,000 in the last 12 months, or do you anticipate any large claims?

☐ Yes ☐ No 4. Have any eligible employees missed a total of 10 or more days due to sickness or injury in the last 12 months?

☐ Yes ☐ No 5. Are you aware of any eligible employees or dependents with a medical problem, history of frequent medical treatment or any other condition expected to generate claims of $10,000 or more over the next 12 months?

☐ Yes ☐ No 6. Have you applied for Group Health Coverage with another carrier who required completion of individual health applications? If so, what was the outcome?

a.☐ Coverage declined b.☐ Quoted rates increased by _____% c.☐ No Change in Rates

Question Number	Check One Employee	Check One Dependent	Age	Date of Recovery	Date of Treatment/ Condition	Nature of Medication	Name of Condition	$ Amount of Claims	Prognosis Current Treatment

III. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in this Employer Risk Appraisal Questionnaire is complete and accurate to the best of my knowledge. I further certify that I hold a position with the company that permits me to have the information necessary to complete this Employer Risk Appraisal Questionnaire on behalf of the company or I have conferred with and confirmed my answers with person(s) that hold such position(s) with the company.

BCBSNE reserves the right to recalculate and change the rates previously proposed, or to decline coverage (unless otherwise provided by state law) based on inadequate or inaccurate disclosures during the RFP or application process which would affect BCBSNE's underwriting or rating decisions.

I understand that BCBSNE may contact employees and dependents to obtain additional follow-up information. I agree to inform employees that BCBSNE may contact them in order to obtain additional information or to discuss information provided on this form. Employer agrees to indemnify BCBSNE for any liability or damages resulting from any breach of representation made in this form and for claims brought by employees and their dependents regarding the use of the information disclosed by employer.

Signature _____ Print Name _____

(Company Executive or Senior Human Resources employee) Title _____

Phone number _____ Date Signed _____

Signature _____ Print Name _____

(Agent/Broker/Consultant) Agency _____

Phone number _____ Date Signed _____