

Georgia Health Coverage



Call For Service (404) 663-8751

GROUP MEDICAL QUESTIONNAIRE

DATE:	_____
BUSINESS NAME:	_____
COMPANY LOCATION(S):	_____ _____ _____
CONTACT NAME:	_____ PH: _____
TYPE OF BUSINESS:	_____
PROPOSED EFFECTIVE DATE:	_____
CURRENT GROUP MEDICAL CARRIER:	_____
TYPE OF PLAN (HMO, POS, PPO):	_____
CURRENT P&C CARRIER:	_____

1. Does the business offer other employee benefits? If yes, please indicate products.
2. How many former employees or dependents are presently covered under COBRA?
3. What is the definition of a full time employee? (hours worked)
4. How many full time employees are not covered under the group medical program?
Please indicate reason not covered for each on back of this form or census form.
(i.e. covered by spouse, not covered, in waiting period)
5. Are part time employees covered under the medical program? If so give details.
6. How many employees are presently disabled or covered under the extension of benefits?
7. How many employees or dependents are presently pregnant? Due date(s)?
8. How many children are physically handicapped or mentally impaired?
9. How many employees or dependents had paid claims in excess of \$10,000 during the past 12 months?
10. How many employees or dependents have been treated for drug abuse, alcohol abuse, or nervous and mental conditions during the past 5 years.
11. How many employess or dependents have been diagnosed with a serious illness (heart disease, cancer, leukemia, AIDS, etc.)?
12. Number employees covered by Workers Compensation?
13. Are owner(s) / officer(s) excluded from Workers Compensation?
14. Employer Contribution: Employee _____% Dependent _____%