GCI
Golden Concierge Insurance

GROUP RISK QUESTIONNAIRE

GENERAL ACCOUNT INFORMATION

Company Name_____Year Founded_____

Contact _____Title_____Company Tax ID#_____

Address _____

City_____State_____Zip Code_____

Other Locations_____

Phone Number_____ Fax _____SIC Code _____

Type of Company (C-Corp, S-Corp, Etc.) _____Nature of Business _____

1. Total number of active employees

   Full Time _____ Part Time _____ Seasonal _____ Variable_____

2. Number enrolled in current medical plan(s) Active Employees _____ COBRA _____ Retirees _____
3. Number of employees currently in waiting period_____
4. Total number of employees waiving current plans due to spousal/parental/military coverage _____Other _____
5. What classes are eligible for employer coverage? Full Time Part Time Retirees Other _____
6. Do you have any employees age 65 or older currently at work? No Yes
7. Do you offer coverage to domestic partners? No Yes

   Same Gender Opposite Gender Both

8. Company waiting period for new hires

GENERAL PLAN INFORMATION

Renewal effective date_____ Number of years with current carrier _____

Current Plan Rates:

Carrier Name	Coverage	EE	Child	Spouse	Children	Family	Group #	Last Rate Increase
		$	$	$	$	$	#	%
		$	$	$	$	$	#	%
		$	$	$	$	$	#	%
		$	$	$	$	$	#	%
		$	$	$	$	$	#	%

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Employer Monthly Contributions:

Percentage: Indicate % for single_____ % for dependent _____

Details:_____

Or

Flat dollar amount : Please complete table

Coverage:	EE:	Spouse:	Child:	Family:
	$	$	$	$
	$	$	$	$
	$	$	$	$
	$	$	$	$

MEDICAL PROFILE

Please complete the medical profile below to the best of your knowledge. Please include information for all covered enrollees including active employees and their dependents. Also include information for COBRA participants.

9. Have any claims greater than $10,000 been paid in the last 3 years? No Yes

10. In the past three years, or in the foreseeable future, do you have any enrolled employees, covered dependent, or COBRA enrollee with a serious continuing claim due to a physical or mental disorder: No Yes

If yes, please indicate the condition on the list below and provide additional details where indicated

Cardiovascular	Infertility	AIDS/Immune Disorders	Diabetes
Neurological	Alcohol Abuse	High Risk Pregnancies	Brain
Pancreas	Arthritis	Drug/Substance Abuse	Organ Transplants
Kidney	Skin	Back, neck	Lupus
Epilepsy	Liver	Stomach	Cancer/Tumor
Blood	Ears/Eyes/Lungs	Stroke/Paralysis	Venereal
Bone/Joint	Emphysema/Pulmonary	Congenital Disorders	Mental/Nervous

Other_____

11. Are any employees/dependents pregnant? No Yes # of pregnancies_____ Due Dates_____

12. Are you aware of any employees or dependents, age 19 or older, who may be considered developmentally disabled or physically handicapped? No Yes details: _____

13. Has any employee missed 10 or more consecutive days of work in the past 5 years due to sickness or injury?

No Yes details: _____

14. Has any employee/dependent been hospitalized or had any surgical operations during the past 5 years?

No Yes Please provide details below.

If you answered "Yes" to any of the previous questions, please provide the following information for the condition:

EE / Dep	Age	Site	Nature of Condition	Dates of Treatment	Medication	Prior Claim	Prognosis/ Current
						$	
						$	
						$	
						$	

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VERIFICATION

The company certifies that, to the best of its knowledge, the information provided above is complete and accurate. Company shall notify the Plan/Insurer promptly of any changes in this information that may affect the eligibility of employees or their dependents including the addition of any newly eligible employees or dependents. Plan/Insurer shall be entitled to rely on the most current information in its possession regarding eligibility of employees and their dependents in providing coverage under this policy.

During and after termination of the Policy, Company grants Plan/Insurer permission to use and/or transfer to third parties for research and analysis purposes the claims and related medical data in Plan/Insurer's possession. The parties shall maintain the confidentiality of any information relating to Covered Persons in accordance with any applicable laws. Neither party shall disclose any confidential business information of the other party without prior written consent of the party.

Employer Signature_____ Date _____

Print Name_____ Title _____

Broker Signature_____ Date _____

Print Name_____ Agency _____