OptimaHealth
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Clear Form

Employer Group Health Questionnaire

☐ Optima Health Plan (Vantage, POS, Design Vantage, Design POS, Equity Vantage, Equity POS)

☐ Optima Health Insurance Company (Plus, Equity Plus, Design Plus)

Group Information *(PLEASE PRINT)*

Legal Group Name		Federal Tax ID Number	
Company Contact		Title	
Phone Number	Fax Number	Email Address	
Company Address	City	State	Zip

General Questions

1. Total number of eligible employees.		2. Total number of employees enrolling for group coverage.	
3. Name of current carrier and plan offered.		4. How long has your company been insured by your current health insurance carrier?	
5. The anniversary date of current plan	Month	Day	Year
6. Are all eligible employees covered by Worker's Compensation?	◯ No		◯ Yes
7. Are any enrolling employees or dependents totally disabled?	◯ No ◯ Yes	If Yes, please explain:	
Name	Age	Date of Disability	mo./day/yr.
Name	Age	Date of Disability	mo./day/yr.
8. Has this employer ever been covered by an Optima Health plan before?	◯ No ◯ Yes	If Yes, dates of coverage mo./day/yr.	mo./day/yr.

Current/Renewal Rates needed

Please provide the following information or attach a copy of your current rates and/or the most recent renewal.

TIER	PRIOR YEAR RATES	CURRENT RATES	RENEWAL RATES
Subscriber Subscriber/Child			
Subscriber/Children			
Subscriber/Spouse			
Family			

Have any eligible employees/dependents/or COBRA participants, been treated or expect to be treated for any of the following conditions?
Please check the appropriate box beside the condition and **if yes, provide details below:**

	Yes	No		Yes	No
HIV	☐	☐	Multiple Sclerosis (MS)	☐	☐
Cancer	☐	☐	Heart or Vascular Disease	☐	☐
Stroke	☐	☐	Alcohol or Substance Abuse	☐	☐
Diabetes	☐	☐	Respiratory Disease/Disorder	☐	☐
Epilepsy	☐	☐	Disease/Disorder of Spine or Back	☐	☐
Organ Transplant	☐	☐	Connective Tissue Disease (Lupus)	☐	☐
Bladder Disease/Disorder	☐	☐	Liver Disorder (Hepatitis/Cirrhosis)	☐	☐
Kidney Disease/Disorder	☐	☐	Nervous/Mental or Psychological Disorder	☐	☐
Stomach/Intestinal Disorder	☐	☐	Acquired Immune Deficiency Syndrome (AIDS)	☐	☐

Details:

(If more room is needed, please attach additional documentation)

Have any employees, dependents or COBRA participants to be covered…		
1. Had medical claims that exceeded $5,000 in the last 24 months for any illness, injury or hospitalization?	☐ **Yes** ☐ **No**	If Yes, please explain:
2. Been hospitalized within the past five years?	☐ **Yes** ☐ **No**	If Yes, please explain:
3. Been advised to have an operation or had an operation within the past five years?	☐ **Yes** ☐ **No**	If Yes, please explain:

Employer Certification

I, the undersigned certify that all of the information shown on this Employer Group Health Questionnaire is true and accurate to the best of my knowledge. It is understood that omission of information on the questionnaire, whether intentional, or unintentional may result in the invalidation of coverage, if in Optima Health Plan's sole judgment, the omitted information was material to the group's rate determination.

Please Print Name | **Title**

Authorized Signature | **Date Signed** ***(Month, Day, Year)***

Print Form