ASPIRUS®
HEALTH PLAN

Agency_____
Agent_____
Agency Number_____

Sales Office_____
Quote Number_____
Is this the agent of record? ❑ Yes ❑ No
How Long?_____

Underwriting Disclosure Statement

Aspirus Health Plan Sales Representative _____
Group Name_____ Nature of Business_____
Group Address_____
City_____ State_____ Zip Code_____ Phone Number_____
Requested Effective Date_____
Does this group have a current health care carrier? ❑ Yes ❑ No
If Yes, carrier name:_____
Number of different carriers the group has had in the past five years?_____
Number of employees eligible for group coverage under the group's current plan?_____
Number of employees enrolled in the group's current plan?_____
Percentage of premium the employer will be contributing?_____

Please answer the following questions to the best of your knowledge in accordance with the group's company records.

1. Has any employee missed 10 consecutive days of work in the past 12 months due to illness or injury? ❑ Yes ❑ No
2. Is any employee NOT performing his or her duties on a full-time basis due to illness or injury? ❑ Yes ❑ No
3. Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period:
   a. Currently confined at home, in a hospital, or any treatment facility? ❑ Yes ❑ No
   b. Had more than $10,000 of medical expenses in the last 24 months? ❑ Yes ❑ No
   c. Been advised to have surgery or be hospitalized which has not yet occurred? ❑ Yes ❑ No
   d. Is an employee or dependent (including spouse) proposed for coverage disabled, unable to work, or not at work because of a current or approaching hospital confinement, leave of absence, or otherwise incapacitated? ❑ Yes ❑ No
4. Has any employee, individual in a retiree class, dependent (spouse or child) COBRA beneficiary, or individual within their COBRA election period received treatment recommended, or had medication prescribed by a doctor, psychiatrist, psychologist, or other licensed practitioner within the past 24 months for any of the following (check all that apply):
   - ❑ AIDS or AIDS-related complex or other immune system disorder
   - ❑ Alcohol or drug abuse or dependence, or psychological disorder
   - ❑ Cancer, cancerous tumor or abnormal growth
   - ❑ Heart or vascular disease, or stroke
   - ❑ Diabetes or any disease or disorder of the kidneys, liver, lungs or blood
   - ❑ Systemic disease such as Lupus, Multiple Sclerosis, Muscular Dystrophy, or Cystic Fibrosis
5. Has any employee, individual in a retiree class, dependent (spouse or child), COBRA beneficiary, or individual within their COBRA election period, being considered for, on a list for, or scheduled for a transplant? ❑ Yes ❑ No

For any "YES" answers given above, please provide additional information below for each individual. If additional space is needed, please use a signed and dated addendum.

Question #	Member Type*	Age	Medical Diagnosis/Condition	Dates of Treatment	Medication Name and Dosage	Past/Current/Future Treatment

*Member Type: E=Employee C=Cobra D=Dependent R=Retiree

During the past 24 months, has the group had medical coverage terminated or a renewal of medical coverage refused? ❑ Yes ❑ No

If yes, please provide details:

Have any medical benefits now or within the past 24 months been partial self-funded or self-funded by the group in any manner other than health insurance premium payments? ❑ Yes ❑ No

If yes, please provide details and attach medical claims experience and monthly enrollment in the plan within three months of the proposed effective date (up to 24 months in arrears).

Are retirees under the age of 65 eligible for coverage under the group's current plan? ❑ Yes ❑ No If yes, how many? _____

Are retirees over the age of 65 eligible for coverage under the group's current plan? ❑ Yes ❑ No If yes, how many? _____

What option is being used for Medicare Part D participation?_____

Current Plan Design

When medical coverage is being requested, please provide the current plan design below. Additionally, please attach a copy of your most recent premium bill and renewal rates.

HMO

Prescription medication copay:_____

Office visit copay:_____

Emergency room copay:_____

Per confinement copay:_____

Pharmacy Benefit:_____

Network:_____

Please list any major provider groups not participating in the above network:

_____

_____

Number of employees in each tier:

Employee:_____

Employee + Child(ren):_____

Employee + Spouse:_____

Family:_____

PPO/POS

Prescription medication copay:_____

Office visit copay:_____

Network:_____

Please list any major provider groups not participating in the above network:

_____

_____

(IN)$ (OUT)$

_____

Number of employees in each tier:

Employee:_____

Employee + Child(ren):_____

Employee + Spouse:_____

Family:_____

Under no circumstances should the group cancel their present group insurance coverage without written notice of approval from Aspirus Health Plan. This risk assessment is intended to help Aspirus Health Plan underwrite the group's request for group insurance. Additional information may be required on employees who are required to answer medical questions for any conditions not disclosed on this form. Any rates provided as a result of this form are subject to change based on additional information received.

Any failure to respond, to the best of the signor's knowledge, to all of the above questions may result in the discontinuance, non-renewal or reformation of any group insurance policy which may be issued by Aspirus Health Plan in reliance upon answers provided by the signer to any or all of the above questions and may result in Aspirus Health Plan's pursuit of any other remedies available to it in law or in equity.

Signature:_____ Title:_____

Date:_____

The broker representing this group certifies that this information is complete and accurate according to the broker's knowledge of the health condition for this group's employees and their dependents. If the broker has any additional information, please attach a signed and dated addendum.

Broker Signature:_____ Date:_____