



6245 N. 24th Parkway, Ste. 201 Phoenix, AZ 85016

Employer Health Information

Please complete the following questions to the best of your knowledge. This information is necessary to evaluate your group's application. In order to protect the individual involved, do not disclose the name of any employee or dependent.

1. Are you aware of any employee, dependent or COBRA enrollee currently disabled? Yes No If yes, explain _____

2. Are you aware of any employee, dependent or COBRA enrollee who incurred expenses of \$5,000 or more in the last 18 months? Yes No If yes, explain _____

3. Are you aware of any employee, dependent or COBRA enrollee who has been advised that necessary surgery or hospitalization is required (including pregnancy)? Yes No If yes, explain _____

4. Are you aware of any employee, dependent or COBRA enrollee who has had an organ transplant such as kidney, liver, heart or lung? Yes No If yes, explain _____

5. Are you aware of any employee or dependent presently or soon to be on COBRA? Yes No If yes, explain _____

6. Are you aware of any employee, dependent or COBRA enrollee who is currently being treated or diagnosed as having cancer, heart/lung disease, high blood pressure, diabetes or AIDS? Yes No If yes, explain _____

7. Are there any employees/dependents who are not actively performing their duties full-time due to a disabling illness, injury or pregnancy? Yes No If yes, please list employee: _____

I represent that, to the best of my knowledge, the information provided on this Employer Health Information Form is complete and accurate. I understand that if I have misstated or omitted any information on this form, the carrier may reassess premium applied to my employer group or terminate coverage in accordance with applicable laws.

Employer Signature

Date