

EVALUATION FORM

Insurance products provided by United HealthCare Insurance Company.



Company Name _____ Bus. Telephone No. () _____

Address _____ Contact Name/ Position _____
STREET CITY STATE ZIP

Nature of Business _____ SIC Code Number of Years in Business _____

Field Sales Rep/Office _____ Field Rep Telephone No. () _____

Agent Name/Office _____ Telephone No. () _____ Commission Requested _____

I. GENERAL PROSPECT INFORMATION

1. Carrier/Plan Information (Please attach a copy of current health plan information.)

a. Please provide 5-year history of previous health insurance coverage, including current carrier:

CARRIER NAME(S)	TYPE(S) OF COVERAGE	PERIOD(S) INSURED
_____	_____	_____
_____	_____	_____

b. Reason for transfer? _____

2. Has the firm ever filed for bankruptcy or is it in the process of filing? Yes No

If Yes, please explain: _____

3. Rates/Contribution

	Current Health Rates	Current Drug Rates	Renewal Health Rates	Renewal Drug Rates
Employee Only	_____	_____	_____	_____
Employee and Spouse	_____	_____	_____	_____
Employee and Children	_____	_____	_____	_____
Family	_____	_____	_____	_____

Effective date of renewal billing rates: _____

Rate Tier requested: 2 tier 3 tier 4 tier

Contributions: Does the Employer contribute to the cost of the plan? Yes No

If yes, indicate percentage of EMPLOYER contributions for: Employee Health coverage _____% Dependent Health coverage _____%

4. Eligibility/Participation

- a. Total number of employees on the payroll (full and part-time) _____
- b. Total number of employees eligible for health coverage (full-time, working 30 or more hours per week) _____
- c. Total number of employees applying for coverage _____
- d. Total number of retirees currently insured _____
- e. Total number of former employees or dependents continuing coverage under COBRA or a State Continuation provision _____

PLEASE PROVIDE THE FOLLOWING INFORMATION. IF NECESSARY, USE ADDITIONAL SHEETS OF PAPER.

Name of Continuee	Employee or Dependent	Date of Birth	Date Continuation Began	Reason/Qualifying Event for Continuation	TYPE OF CONTINUATION	
					COBRA (Wks. Remaining)	State Continuation (Wks. Remaining)
_____	_____	_____	_____	_____	_____	_____

f. Do you offer coverage to 1099 workers? Yes No If Yes, how many? _____

g. Do all employees have Workman's Compensation coverage? Yes No

If not, list which employees do not, and reason: _____

h. Does the employer endorse any other health plans? Yes No If Yes:

TYPE OF PLAN	EFFECTIVE DATE	NO. OF EEs ENROLLED	% ER CONTRIBUTION
_____	_____	_____	_____

i. Total number of sites: _____

List sites requiring health coverage: _____

Number of eligibles at this site: _____

II. MEDICAL PROFILE

Answer the following questions to the best of your knowledge for all eligible employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Please provide details to "Yes" answers in the space provided.

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

	YES	NO
1. Have any employees or dependents been diagnosed or treated during the past five years for heart disease, high blood pressure, stroke, diabetes, seizures, kidney disease, back disorders, chronic lung disorders, cancer, tumors, congenital disorders, alcohol or drug abuse, mental or nervous conditions, muscular dystrophy, multiple sclerosis or AIDS, ARC, HIV infection (not applicable in Wisconsin)?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have any employees or dependents had medical claims in excess of \$7500 during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are any employees or dependents, whether or not applying for coverage, currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have any employees or dependents been hospitalized or had any surgical operations during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have any employees been absent from work for more than two consecutive weeks due to illness or injury during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have any dependents been confined to the home or incapacitated for more than two consecutive weeks due to illness or injury during the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have any employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next six months?	<input type="checkbox"/>	<input type="checkbox"/>
8. Are any employees or dependents currently taking any prescription medications for any chronic or serious conditions?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the group or have any employees or dependents been declined or rated-up for health insurance coverage within the past two years?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are any employees or dependents receiving disability benefits of any type?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes" to any of the questions in "II. MEDICAL PROFILE", please provide the requested information for each individual. If necessary, use additional sheets of paper.

QUESTION NUMBER	(CHECK ONE)		AGE	DATES OF TREATMENT/ RECOVERY DATE	NATURE OF CONDITION	NAME OF MEDICATION	DOLLAR AMOUNT OF CLAIMS	PROGNOSIS/ CURRENT TREATMENT
	EMP.	DEP.						

III. PLEASE ATTACH THE FOLLOWING ITEMS TO THIS FORM:

- A copy of your current carrier's latest premium billing statement and current plan design information.
- A copy of your current carrier's latest renewal letter.
- A copy of most recent census information for all eligible employees, split by site.
- A copy of your state unemployment tax report for the last two completed quarters.

I represent to the best of my knowledge the information I have furnished is accurate, and includes any employees and dependents who have elected continuation of insurance benefits. I understand that material omissions, misrepresentations or misstatements in the information requested on this form can result in the voiding or reformation of insurance. Any person who knowingly presents false or fraudulent information in an application for insurance is guilty of crime and may be subject to fines and confinement in prison.

Signature _____ Title: _____ Date: _____
(Owner or Officer of Firm)