



CONSOLIDATED BENEFITS

An Employer's Best Friend

3081 Gilchrist Road

Suite 110

Akron, OH 44305

800-733-3165

(within Ohio)

330-733-3123

Fax 330-733-3214

EMPLOYER DATA / MEDICAL QUESTIONNAIRE

GROUP NAME _____ DATE _____

- 1) Total number of eligible, full-time employees: _____
- 2) Total number of employees currently insured for medical: _____
- 3) Employer contribution for: Single _____ Family _____
 (% of Premium or \$ Amount)
- 4) Number of retired employees covered: Under 65 _____ Over 65 _____
- 5) Name of insured or dependents eligible or covered under COBRA & dates: _____
- 6) Name of insureds or dependents disabled, hospitalized, or not actively at work.

- 7) Any insured or dependents incurred \$10,000 or more in medical claims in the last 12 months, or anyone apt to incur in the next 12 months. If so, please provide employee name and diagnosis: _____

- 8) Are there any employees or dependents with a scheduled hospitalization or surgery pending? If so, explain: _____

Are there any employees or dependents with any of the following conditions:

Please answer "to the best of your knowledge."

- AIDS / HIV
- Arthritis
- Asthma / Bronchitis
- Back / Spinal Problems / Disorders / Scoliosis
- Bowel / Stomach Disorders
- Cancer / Leukemia / Lymphoma / Melanoma
- Cancer (Present)
- Cancer (Recovered Over 3 Years)
- Cancer (Recovered Over 5 Years)
- Cerebral Palsy
- Coronary Artery Disease (Last 5 Years)
- Crohn's Disease (Present)
- Cystic Fibrosis
- Diabetes (Diet Control)
- Diabetes (Oral Medications)
- Diabetes (Insulin)
- Drug / Alcohol Abuse (Treated in 3 Years)
- Emphysema (Uncomplicated)
- Epilepsy (Grand Mal)
- Epilepsy (Others Non-Febrile)

- Heart Attack (Coronary Bypass)
- Kidney Dialysis
- Kidney Dialysis (Pending Transplant)
- Liver (Cirrhosis, Hepatitis, Non-Alcoholic)
- Liver (Pending Transplant)
- Lung Abscess Present
- Lupus
- Mental Disorders (Present)
- Major Depression
- Anxiety Disorders
- Psychotic Disorders
- Muscular Dystrophy / Sclerosis
- Paralysis
- Pericarditis
- Pregnancy (Due Date _____)
- Spina Bifida
- Stroke (Within Last 5 Years)
- Transplants (Not Listed Elsewhere)
- Tuberculosis (Pulmonary)
- Tumors / Growths

Signature _____

Authorized Company Official

Title _____