# Employer Risk Appraisal

1. This questionnaire is designed to provide information specific to your group.
2. The information will be used in evaluating the risk characteristics of your group to more accurately establish rates, benefits, and eligibility rules as part of your application for coverage.
3. Please answer all questions to the best of your knowledge.
4. Groups of 1-24, please complete sections 1, 2 and 3 and sign the back of the form. Groups of 25+, complete all sections and sign the back.

EMPLOYER'S TAX IDENTIFICATION NUMBER

BROKER NAME

**PLEASE PRINT. DO NOT WRITE IN SHADED AREAS. COMPLETE BOTH SIDES, IN INK.**

## 1. BUSINESS PROFILE

BUSINESS NAME | TELEPHONE NUMBER

BUSINESS ADDRESS *(MUST BE A PHYSICAL STREET ADDRESS)* | CITY | COUNTY | STATE | ZIP | COUNTY CODE

BUSINESS HEADQUARTERS *(CITY, COUNTY, STATE)* | OTHER BUSINESS LOCATIONS *(CITY, COUNTY, STATE)* | CONTACT NAME AND POSITION

TYPE OF BUSINESS | NAICS CODE | YEARS OF OPERATION | Small Employer as defined by North Carolina Statutes (NCGS 58-50-110[22])? ☐ Yes ☐ No
**A small employer has 50 or less eligible full-time employees.**

What type of ownership is this business entity? ☐ Proprietorship ☐ Self-Employed ☐ Partnership ☐ Statutory 1099 Employee ☐ Limited Liability Corporation ☐ Church/Nonprofit ☐ Corporation ☐ Other: _____

Ever filed for bankruptcy or in the process of filing? ☐ Yes ☐ No | INDICATE CHAPTER FILED | Has the Bankruptcy Court approved reorganization? ☐ Yes ☐ No **Please provide documentation of approval to reorganize.**

## 2. GROUP ELIGIBILITY PROFILE

This information will be compared to actual enrollment, if your group does enroll. A difference between the enrollment information in the "Group Eligibility Profile" shown here and actual enrollment may invalidate the proposed rates.

a. Total number of employees, including full-time and part-time ..... _____

b. Total number of employees eligible for health coverage, including employees who will be eligible upon completion of their probationary period ..... _____

***The group certifies that all individuals enrolling for coverage meet the following definition of eligible employee:***
**An "eligible employee" means an employee who works for a small employer on a full-time basis, with a normal work week of 30 or more hours, including a sole proprietor, a partner or a partnership, or an independent contractor, if included as an employee under a health care plan of a small employer; but does not include employees who work on a part-time, temporary, or substitute basis. When determining employee eligibility for groups of 51 or more employees, an individual proprietor, owner, or operator shall be defined as an "eligible employee" for the purpose of obtaining coverage under the employee group health plan and shall not be held to a minimum workweek requirement as imposed on other eligible employees. An individual who is an "employee" as that term is defined under Internal Revenue Code Section 3121 (d) (3) and works on a full-time basis for the group may be considered eligible for coverage; documentation of such "employee" status is required. For groups defined as Small Employer groups, persons whose compensation is reported entirely on 1099 Forms are not generally considered eligible.**

c. Are a majority of these eligible full-time employees employed in the State of North Carolina? ☐ Yes ☐ No

d. Total number of employees applying for health coverage ..... _____

e. Total number of employees applying for dental coverage ..... _____

f. Total number of employees who are not applying that have other group coverage ..... _____

g. Total number of former employees or their dependents continuing coverage through COBRA or state continuation provisions ..... _____

Please provide the following information:

| NAME OF PARTICIPANT | EMP. | OR DEP. | AGE | NATURE OF QUALIFYING EVENT | DATE OF QUALIFYING EVENT | MONTHS REMAINING |
|---|---|---|---|---|---|---|
| | ☐ | ☐ | | | | |
| | ☐ | ☐ | | | | |
| | ☐ | ☐ | | | | |

h. Will all employees and their dependents enrolling for health coverage be required to enroll for dental coverage? ..... ☐ Yes ☐ No ☐ Not applying for Dental Coverage

i. Are all eligible employees covered by workers' compensation (the owner is not required to be covered on workers' compensation for groups with 1-3 eligible employees)? ..... ☐ Yes ☐ No

j. Please indicate the probationary period requested for new employees ..... ☐ 0 ☐ 30 ☐ 60 ☐ 90

k. Is this entity a Professional Employer Organization (PEO)? ..... ☐ Yes ☐ No

l. Is your business currently enrolled in a Professional Employer Organization with leased employees? ..... ☐ Yes ☐ No

m. For groups of 51 or more eligible employees: Will employees and their dependents be subject to a waiting period for pre-existing conditions (health coverage only)? ..... ☐ Yes ☐ No

**If yes,** what is the pre-existing condition option you are selecting? (Please check one option below)

**(First Option Applies to all Small Employer Groups)**

☐ Pre-existing waiting period applies to all enrollees (timely and late) (Applies to All Small Employer Groups)

☐ Pre-existing waiting period is waived for group's original effective date enrollees; Pre-existing waiting period applies to subsequent enrollees (timely and late)

☐ Pre-existing waiting period waived for group's original effective date enrollees and subsequent timely employees; Pre-existing waiting period applies to late enrollees

n. Are any full-time employees employed outside of North Carolina? (see 2b for definition of full-time employee) ..... ☐ Yes ☐ No

Please provide the following information:

| STATE OF RESIDENCE | NUMBER EMPLOYED | STATE OF RESIDENCE | NUMBER EMPLOYED |
|---|---|---|---|
| | | | |
| | | | |

o. Are there any other employer sponsored health plans which will be in force concurrently (other employer sponsored health plans do not include dental, life or disability plans)? ..... ☐ Yes ☐ No

Please provide the following information:

| CARRIER | TYPE OF BENEFITS | NUMBER ENROLLED | % EMPLOYER CONTRIBUTION |
|---|---|---|---|
| | | | |

## 3. CURRENT CARRIER PROFILE

a. Please provide a five year history of group health insurance carriers, including your current carrier:

| CARRIER NAME(S) | PERIOD(S) INSURED START DATE | END DATE | REASON FOR TRANSFER |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

b. Please provide your current and renewal health rates, including any prescription drug riders:

| CARRIER NAME(S) | NUMBER OF SUBSCRIBERS | CURRENT HEALTH RATES | RENEWAL HEALTH RATES |
|---|---|---|---|
| Employee Only | | | |
| Employee + 1 | | | |
| Employee + 2 or more | | | |
| Employee and Child(ren) | | | |
| Employee and Spouse | | | |
| Employee and Family | | | |

c. What is the employer's contribution to the cost of the health program? **(minimum contribution is 50%)**

Employee coverage _____% Dependent coverage _____%

d. What is the employer's contribution to the dental program?

Employee coverage _____% Dependent coverage _____%

e. Please attach a copy of these forms to complete the appraisal:

- ☐ Current health carrier's latest billing statement and a description of benefits.
- ☐ Current employee census, showing age or date of birth, split by business location.
- ☐ Current health and dental carrier's latest renewal letter.
- ☐ Dental carrier's latest billing statement.

f. Will employees and their dependents be subject to a dental waiting period? **If yes,** please select dental waiting period option below:

- ☐ Applies to All
- ☐ Waived for Initial & Subsequent Timely enrollees, applies to Late enrollees (proof of prior coverage is required)

## 4. HEALTH INFORMATION PROFILE

Please provide the answers to the following questions to the best of your knowledge as they pertain to all eligible employees and/or covered dependents. It is important that you include information pertaining to those members continuing through COBRA or state continuation programs.

a. Has any person to be covered had any of the following conditions?

| CONDITION | YES | NO | CONDITION | YES | NO | CONDITION | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Heart disease | ☐ | ☐ | Seizures | ☐ | ☐ | Cancer, Tumors | ☐ | ☐ |
| High blood pressure | ☐ | ☐ | Back disorders | ☐ | ☐ | Liver disorder | ☐ | ☐ |
| Stroke | ☐ | ☐ | Chronic lung disorders | ☐ | ☐ | Multiple Sclerosis | ☐ | ☐ |
| Diabetes or high blood sugar | ☐ | ☐ | Muscular Dystrophy | ☐ | ☐ | Kidney Disease | ☐ | ☐ |
| Nervous System disorder | ☐ | ☐ | Alcohol or drug dependency or abuse | ☐ | ☐ | Acquired Immunity Deficiency Syndrome or Human Immuno-deficiency Virus Infection | ☐ | ☐ |
| Mental Disorder/Depression | ☐ | ☐ | | | | | | |

b. Are any eligible employees or dependents currently pregnant? ..... ☐ Yes ☐ No

c. Are any employees or dependents scheduled for hospitalization and/or surgery? ..... ☐ Yes ☐ No

For each item checked "Yes" above, please explain below *(If more space is needed, attach a separate sheet)*:

| DIAGNOSIS | TREATMENT AND MEDICATIONS | LAST DATE TREATED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## 5. STATEMENT OF UNDERSTANDING

I understand and do hereby certify that the information contained in the Employer Risk Appraisal is complete, including attachments, and accurate to the best of my knowledge. It is further understood that any misrepresentation or false statements will subject any issued Group Contract to immediate termination by Blue Cross and Blue Shield of North Carolina.

Owner or Authorized Executive Signature _____ Date _____

Print Name _____