Clear Form

Sentara Health Plans

1300 Sentara Park
Virginia Beach, VA 23464

# *Employer Group Health Questionnaire*

☐ Sentara Health Plans (Vantage, POS, Vantage HRA, POS HRA, Vantage HSA, POS HSA)

☐ Sentara Health Insurance Company (Plus, Plus HSA, Plus HRA)

## Group Information *(PLEASE PRINT)*

| | | | |
|---|---|---|---|
| Legal Group Name | | Federal Tax ID Number | |
| Company Contact | | Title | |
| Phone Number | Fax Number | Email Address | |
| Company Address | City | State | Zip |

## General Questions

| | | |
|---|---|---|
| 1. Total number of employees | 2. Total number of eligible employees | 3. Total number of employees enrolling for group coverage |

| | |
|---|---|
| 4. Name of current carrier and plan offered | 5. How long has your company been insured by your current health insurance carrier? |
| 6. The anniversary date of current plan _____ *mm/dd/yyyy* | 7. Are all eligible employees covered by Worker's Compensation? ◯ No ◯ Yes |
| 8. Are any enrolling employees or dependents totally disabled? ◯ No ◯ Yes | If Yes, please explain: |

| | | |
|---|---|---|
| Name | Age | Date of Disability _____ *mm/dd/yyyy* |
| Name | Age | Date of Disability _____ *mm/dd/yyyy* |
| 9. Has this employer ever been covered by a Sentara plan before? ◯ No ◯ Yes | | If Yes, dates of coverage _____ *mm/dd/yyyy* _____ *mm/dd/yyyy* |

| | | |
|---|---|---|
| 10. ◯ Contract Year ◯ Calendar Year | New Hire Waiting Period | Employer Contribution |

## Current/Renewal Rates needed

**Please provide the following information or attach a copy of your current rates and/or the most recent renewal.**

| TIER | PRIOR YEAR RATES | CURRENT RATES | RENEWAL RATES |
|---|---|---|---|
| Subscriber<br>Subscriber/Child | | | |
| Subscriber/Children | | | |
| Subscriber/Spouse | | | |
| Family | | | |

Have any eligible employees/dependents/COBRA participants been treated or expect to be treated for any of the following conditions?

Please check the appropriate box beside the condition and if yes, provide details below:

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| HIV | ☐ | ☐ | Multiple Sclerosis (MS) | ☐ | ☐ |
| Cancer | ☐ | ☐ | Heart of Vascular Disease | ☐ | ☐ |
| Stroke | ☐ | ☐ | Alcohol or Substance Abuse | ☐ | ☐ |
| Diabetes | ☐ | ☐ | Respiratory Disease/Disorder | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | Disease/Disorder of Spine or Back | ☐ | ☐ |
| Organ Transplant | ☐ | ☐ | Connective Tissue Disease (Lupus) | ☐ | ☐ |
| Bladder Disease/Disorder | ☐ | ☐ | Liver Disorder (Hepatitis/Cirrhosis) | ☐ | ☐ |
| Kidney Disease/Disorder | ☐ | ☐ | Nervous/Mental or Psychological Disorder | ☐ | ☐ |
| Stomach/Intestinal Disorder | ☐ | ☐ | Acquired Immune Deficiency Syndrome (AIDS) | ☐ | ☐ |

Details:

*(If more room is needed, please attach additional documentation)*

| **Have any employees, dependents, or COBRA participants to be covered...** | | |
|---|---|---|
| 1. Had medical claims that exceeded $5,000 in the last 24 months for any illness, injury or hospitalization? | ◯ Yes<br>◯ No | If Yes, please explain: |
| 2. Been hospitalized within the past five years? | ◯ Yes<br>◯ No | If Yes, please explain: |
| 3. Been advised to have an operation or had an operation within the past five years? | ◯ Yes<br>◯ No | If Yes, please explain: |

## Employer Certification

**I, the undersigned, certify that all of the information shown on this Employer Group Health Questionnaire is true and accurate to the best of my knowledge. It is understood that omission of information on the questionnaire, whether intentional, or unintentional may result in the invalidation of coverage, if in Sentara's sole judgment, the omitted information was material to the group's rate determination.**

**Please Print Name** _____ **Title** _____

**Authorized Signature** _____ **Date Signed** *mm/dd/yyyy* _____

**Print Form**