PrestigePEO™

Group Health Questionnaire

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. The questionnaire will not be accepted if incomplete. Use additional paper if necessary.

Company and Current Enrollment Information

Company Name: _____

Address: _____ _____
Street Suite #

_____ _____ _____ _____
City State Zip County

Benefits Contact Name: _____ Benefits Contact Phone #: _____

Total Number of Employees on Payroll: _____ Total Full Time: _____ Total Part Time: _____

Total Number of employees currently: Enrolled in Healthcare plan _____ On Disability _____

Payroll Cycle: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly Number of Payroll delivery sites: _____

State Unemployment Rates within each state the company currently conducts business: _____

Are any health plan enrollees NOT paid employees (other than spouses or children)?: ☐ Yes ☐ No

If yes, please provide names and details:

Current Health Carrier: _____ Health Carrier Renewal Date: _____

Is your current plan self-funded?: ☐ Yes ☐ No ☐ Don't Know ***If yes, please provide claims

Are you currently with a PEO?: ☐ Yes ☐ No If yes, provide PEO name: _____

Any ineligible class of employees: ☐ Yes ☐ No If yes, which class: _____

Please provide a complete description of your business operation:

SIC Code: _____ Number of Locations: _____ Please identify all states of operation: _____

Has your company ever been denied a health insurance quote from an insurance carrier, a reinsurance company, or a PEO?: ☐ Yes ☐ No If yes, provide PEO name

A. List any current participants in COBRA / State Continuation (use additional paper if necessary): ☐ NONE

Name	DOB	Zip Code	Coverage Tier	COBRA Effective Date	End Date	Enrolled	Eligible
						☐	☐
						☐	☐
						☐	☐

B. List any participants currently eligible for COBRA who have not yet elected coverageand/or any participants who will become eligible for COBRA prior to the Health Planeffective date (use additional paper if necessary): ☐ NONE

Name	Date Eligible	Activating Event/Date

C. List any employees and/or dependents who are on the health plan that are disabled: ☐ NONE

Name	Disability	Qualifying Event

Next, please answer the following questions on behalf of your company to the best of your knowledge. It is not necessary to transfer information from Personal Health Questionnaires. You may include additional sheets for detailed explanations.

General Illness Questions

a. Has anyone been treated for a serious illness, been hospitalized or had surgery inthe past 5 years? ☐ Yes ☐ No

b. Is anyone currently hospitalized, confined at home, incapacitated, confined in atreatment facility, incapable of self-support because of physical or mental disability? ☐ Yes ☐ No

c. Has anyone been advised that medical treatment, diagnostic testing, surgery orhospitalization is necessary? ☐ Yes ☐ No

(If yes to any or all, please provide details in the table below.)

Specific Illness Questions

Is anyone currently being treated or been advised to seek treatment for any of the following?

Please select all that apply:

- ☐ AIDS or testing HIV Positive
- ☐ Arthritis
- ☐ Back disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart disease
- ☐ Kidney disorder
- ☐ Liver disease
- ☐ Mental illness
- ☐ Muscular disorder
- ☐ Nervous system disorders
- ☐ Respiratory disease
- ☐ Stroke
- ☐ Substance dependency
- ☐ Transplants
- ☐ Tumor
- ☐ Other serious conditions

(If any boxes are selected, please provide details in the table below.)

Name	Sex	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

Is Anyone Currently Pregnant?: ☐ Yes ☐ No

If yes, please provide due date and note below if normal, high risk, multiple birth, or preterm labor with this pregnancy.

This includes employees, dependents or COBRA participants.

Name	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

Client Privacy Notifications

Thank you for completing the requested information above. Any non-public personal information (i.e., Name with address and/or social security number, and detailed health information (protected health information)) that you provide via hard copy or through the data collection process will be used solely for the purpose of providing risk assessment to the Professional Employer Organization (PEO), Multiple Employer Welfare Arrangement (MEWA), association group (Association), or Trust that will provide a health insurance quote to the employer. The information will not be sold, licensed, transmitted, or disclosed outside of authorized parties unless: a) necessary for providing services on behalf of the PEO/MEWA/Association/Trust, b) expressly authorized by you, c) necessary for backup documentation purposes, or d) required by law.

I,_____ (as represented by "*Authorized Signature*" below) certify on behalf of the client company ("company") that the statements comprised of aggregate health information regarding the company's employees ("employees") are true and correct to the best of my knowledge. I understand that this form is used for information purposes only and does not bind coverage. I will notify **Prestige Employee Administrators, LLC and/or other affiliated professional employer organizations, collectively known as PrestigePEO**, of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage.

In the event that material information has been omitted or is inaccurate, the insurance carrier may deny, limit, or retroactively terminate coverage back to the coverage inception date. Furthermore, the PrestigePEO service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases, I understand that PrestigePEO may also adjust the company's insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation.

PrestigePEO gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

Note: Prospective employees in the states of Michigan, New York, Washington, and California should not provide information regarding height or weight. PrestigePEO's Notice of Privacy Practices ("NOPP") provides more detailed information about how PrestigePEO and the health plan chosen on behalf of the company may use and disclose employee protected health information. Both I and the employees have a legal right to review this NOPP before I sign this consent on behalf of the company and are encouraged to read it in full. The employees have a right to request restrictions on how their protected health information is used and disclosed. PrestigePEO and the health plan are not required by law to grant such a request; however, if such a request is granted, PrestigePEO and the health plan are bound by their agreement. I, on behalf of the company, have a right to revoke this consent in writing, except to the extent PrestigePEO or the health plan has already used the disclosed protected health information in reliance upon this consent.

Information disclosed on this form is considered valid for effective dates within 90 days of the date signed. I will notify PrestigePEO of any changes that occur after signing this Group Health Questionnaire and prior to starting health coverage. I understand that PrestigePEO reserves the right to re-underwrite based on a change in the Census or Demographics.

Authorized Signature	Title	Date
Print Name	Print Name of Company	