



RISK SCREENING FORM

Name of Prospect (Company Name): Business Telephone No.: Fax

GENERAL PROSPECT INFORMATION

1. Type of Business: Number of years business established:
2. Carrier/Plan Information
A. Has group been previously insured by Multicover/NetCare for Group Health?
B. Name of current health insurance carrier: How long w/ current carrier?
C. Reason for transfer:
D. Does your current medical plan include an extension of benefits provision for retirees or disabled employees and dependents upon cancellation?
3. Employer Contribution/ Rates:
A. Employer Contribution %
Current Premium Rates: \$ Single \$ 2-Party \$ Family

ELIGIBILITY/ENROLLMENT INFORMATION

No. of Eligible Employees: No. of Employees in Waiting Period: No. of Part-Time Employees:
No. of Employees Covered: No. of Employees of COBRA: No. of Retired Employees Covered:

MEDICAL PROFILE

Answer the following questions to the best of your knowledge for the persons to be insured: (employees, spouses, children)

(Give details to questions answered 'Yes' in the space provided below)

A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?
B. Has anyone had a claim of \$5,000 or more in the past 12 months?
C. Is anyone apt to have a continuing claim from an existing medical or physical disorder?
D. Has anyone been advised to have surgery in the last six months, or anticipate hospitalization for any other reason?
E. Are any of the employees or their dependents pregnant?
F. Have any employees missed 10 or more consecutive days of work in the past 12 months due to illness, injury or ongoing medical treatment?
G. Are there any employees or dependents who are confined at home, incapacitated or confined in a hospital or treatment facility?
H. Are there any spouses or dependents who are not actively at work performing his or her duties full time due to illness, injury or ongoing medical treatment?
I. Are there any employees or dependents not now insured who have ever been declined for life or medical coverage?
J. Do any employees or dependents smoke cigarettes?

If you have answered "YES" to any of these questions, please give details below:

Blank lines for providing details for 'Yes' answers.

The Applicant certifies that the information on this form is complete and true to the best of his/her knowledge. Groups employing 10 employees or less will be required to submit SWICA information and will be required to enroll 100% of eligible employees (unless they are covered under another health plan). Should any information differ upon submission of enrollment applications, NetCare reserves the right to re-develop the rates or decline to cover the group.

Applicant's Signature Title Date