HRDelivered

PEO Information Request (page 1 of 4)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. HRDelivered will not accept the questionnaire if incomplete.

Date _____ Proposed Effective Date: _____

I. COMPANY AND CURRENT ENROLLMENT INFORMATION					
Company Name					
Street Address					
City		**State**		**Zip**	
County		**Benefits Contact & Phone #**			
Total Number of employees on payroll:		**Total Full Time:** **Total Part Time:**		**Total Number of employees currently enrolled in health care plan:**	
Current Health Carrier:			**Health Carrier Renewal Date: _____/_____/_____**		
Years with Current Carrier:			**Renewal Rates Received?** ☐ ***Yes*** ☐ ***No***		
Is Claims Experience available for your group? ☐ ***Yes (provide reports)*** ☐ ***No***					
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, name of PEO:**			**Does your Company currently have a Wellness Program in place?** ☐ ***Yes*** **(attach details)** ☐ ***No***		
Please provide a description of your business operation:			**Does your Company currently have a Smoking or Tobacco Cessation program in place?** ☐ ***Yes*** ☐ ***No***		
Number of Locations: _____		**Please identify all states of operation: _____**			
Are any health plan enrollees NOT paid employees (other than spouses or children)? ☐ ***Yes*** ☐ ***No***					

A. List any current COBRA / State Continuation participants: ☐ *NONE*

Name / DOB / Phone # of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)

B. List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date: ☐ *NONE*

Name / DOB / Phone # of Individual	Date Eligible	Activating Event/Date

II. CURRENT HEALTH PLAN EMPLOYER CONTRIBUTION INFORMATION

(Does your company have more than one Contribution Level? If so, please list each separately)

	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels ($ or %)				
Company Contribution Levels ($ or %)				

III. RATE HISTORY & PLAN DESIGN DETAILS (include the 3 most elected plans)

Plan 1 Name:_____	**# Enrolled** _____	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ _____
Employee + Spouse	#	$	$	Co-Insurance % _____
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ _____ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ _____
				Prescription Drugs___/___/____

Plan 2 Name:_____	**# Enrolled** _____	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ _____
Employee + Spouse	#	$	$	Co-Insurance % _____
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ _____ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ _____
				Prescription Drugs___/___/____

Plan 3 Name:_____	**# Enrolled** _____	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ _____
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ _____
Employee + Spouse	#	$	$	Co-Insurance % _____
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ _____ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ _____
				Prescription Drugs___/___/____

- **Attach a copy of your benefit & billing summary for each plan and year listed above.**
- **Include carrier claims report if available.**

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Next, please answer the following questions on behalf of your company <u>to the best of your knowledge</u>. This information will help determine if your group is best served by the implementation of a wellness program, as part of the Affordable Care Act.

IV. WELLNESS PROGRAM IMPACT APPRAISAL	
A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?	To the Best of My Knowledge ❑ YES ❑ NO
B. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?	❑ YES ❑ NO
C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary? *(If yes to any, please provide details in the table below.)*	❑ YES ❑ NO

D. If anyone is currently being treated or been advised to seek treatment for any of the following, **please check 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 disorde
- ❑ respiratory disease
- ❑ stroke
- ❑ substance dependency
- ❑ transplants
- ❑ tumor
- ❑ other serious conditions

(For all checked boxes, please provide details below)

Name (**optional**)	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery
	M						
	M						
	M						
	M						
	M						
	M						

C. List any employees and/or dependents who are on the health plan that are disabled:

❑ **NONE**

Name (optional)	Disability	Qualifying Event

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Is Anyone Currently Pregnant? 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.*	To the Best of My Knowledge: ❑ YES ❑ NO

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

I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind enrollment or coverage. I will notify HRDelivered of any changes that occur after signing this questionnaire.

In the event that material information has been omitted or is inaccurate, HRDelivered service agreement may terminate for breach of contract resulting from the material misrepresentation.

HRDelivered 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.

HRDelivered Program Notice of Privacy Practices provides more detailed information about how HRDelivered Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. HRDelivered Program and my health plan are not required by law to grant my request. However, if my request is granted, HRDelivered Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent HRDelivered Program or my health plan have already used or disclosed my protected health information in reliance upon my consent.

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

Authorized Signature	**Title**	**Date**
Print Name	**Print Name of Company**	
Broker / Sales Signature	**Broker / Sales Print Name**	**Date**