EMPLOYER HEALTH INSURANCE QUOTE REQUEST FORM

For questions or assistance with completing this form, please contact your LehrmanGroup broker.

LehrmanGroup
Health Insurance Brokers

COMPANY INFORMATION

COMPANY NAME	PLANNED EFFECTIVE DATE FOR INSURANCE
ADDRESS	
CITY, STATE, ZIP	
TELEPHONE	FAX
CONTACT PERSON	CONTACT EMAIL
NATURE OF BUSINESS (SIC CODE)	TAX ID #

EMPLOYEE/PLAN INFORMATION

NUMBER OF EMPLOYEES	EMPLOYER CONTRIBUTION/WAIT	RENEWAL DATE	CARRIER	
TOTAL	EMPLOYEE	CURRENT	CURRENT	# YRS
ELIGIBLE	DEPENDENTS	DESIRED	PREVIOUS	# YRS
PARTICIPATING	WAITING PERIOD		PREVIOUS	# YRS
COBRA	CARVE OUT?		PREVIOUS	# YRS

CURRENT RATES

HMO CURRENT	HMO RENEWAL	PPO CURRENT	PPO RENEWAL	VISION CURRENT	VISION RENEWAL	DENTAL CURRENT	DENTAL RENEWAL
EE							
EE+SP							
EE+CH							
FAMILY							

CURRENT PLAN INFORMATION

HMO PPO POS HSA	COINSURANCE	PCP/SP COPAY	OUT OF POCKET MAX	LIFETIME MAX
DEDUCTIBLE				

BENEFITS REQUESTED

HMO PPO POS HSA	DEDUCTIBLE	COINSURANCE	OUT OF POCKET MAX	LIFETIME MAX
PCP/SP COPAY	DENTAL: PPO DMO VOLUNTARY	VISION	ST DISABILITY LT DISABILITY	LIFE

KNOWN HEALTH CONDITIONS

CIRCLE ALL THAT APPLY TO EMPLOYEES, SPOUSES, AND/OR DEPENDENTS. FOR ANY CONDITION CIRCLED EMPLOYEE MUST FILL OUT HEALTH HISTORY FORM.

ARTHRITIS BACK/NECK CANCER CARDIAC TESTS CROHNS DIABETES EPILEPSY HEART DISORDER HIV/AIDS HYPERTENSION KIDNEY DISORDER LUNG DISORDER

LUPUS MD MS OPEN HEART SURGERY ORGAN TRANSPLANT PREGNANCY PSYCHOLOGICAL DISORDER STROKE ALCOHOL/DRUG ABUSE

ANY OTHER CONDITION NOT LISTED:

COMPANY CENSUS FORM

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	M/F	DOB	AGE	EE	EE+SP	EE+CH	FAM	SP. AGE	# CHILDREN	ZIP CODE	TITLE	SALARY
1				○	○	○	○					
2				○	○	○	○					
3				○	○	○	○					
4				○	○	○	○					
5				○	○	○	○					
6				○	○	○	○					
7				○	○	○	○					
8				○	○	○	○					
9				○	○	○	○					
10				○	○	○	○					
11				○	○	○	○					
12				○	○	○	○					
13				○	○	○	○					
14				○	○	○	○					
15				○	○	○	○					
16				○	○	○	○					
17				○	○	○	○					
18				○	○	○	○					
19				○	○	○	○					
20				○	○	○	○					
21				○	○	○	○					
22				○	○	○	○					
23				○	○	○	○					
24				○	○	○	○					
25				○	○	○	○					
26				○	○	○	○					
27				○	○	○	○					
28				○	○	○	○					
29				○	○	○	○					
30				○	○	○	○					
31				○	○	○	○					
32				○	○	○	○					
33				○	○	○	○					
34				○	○	○	○					
35				○	○	○	○					
36				○	○	○	○					
37				○	○	○	○					
38				○	○	○	○					
39				○	○	○	○					

LehrmanGroup 2900 North Swan Road, Suite 102 Tucson, AZ 85712-6008 T (520) 760-0392 (800) 600-9663 F (520) 760-0793 http://www.lehrmangroup.com

Employee & Family Questionnaire

This form is used to determine health insurance rates for an employer. It is required by employers with less than 26 employees that are seeking health insurance for their employees. This form is not an application for health insurance and it is not a guarantee of coverage through your employer.

- PLEASE COMPLETE THIS APPLICATION IN FULL.
- PLEASE USE BLACK INK - NO PENCILS.
- ALL YES ANSWERS MUST BE EXPLAINED IN DETAIL IN THE TABLE ON PAGE TWO.
- PLEASE DO NOT LIST HEALTH HISTORY FURTHER THAN 5 YEARS BACK

YOU HAVE THE RIGHT FOR THIS INFORMATION TO REMAIN CONFIDENTIAL.

YOU MAY GIVE THIS INFORMATION TO YOUR EMPLOYER/HR REPRESENTATIVE OR SEND DIRECTLY TO THE BROKER:

FAX: 520-760-0392
EMAIL: groups@lehrmangroup.com
MAIL: Lehrman Group, 2900 N. Swan Rd, Ste 102, Tucson, AZ 85712

In case we need to reach you regarding this form, please provide us with:

Your employer_____
Your first and last name_____
Your phone number_____

If you have any questions or need assistance, please call us at 520-760-0392, or toll free at 800-600-9663.

Employee and Family Medical Questionnaire

Section 1: Employer/Employee Information

Employer Name: _____

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height (feet, inches)	Weight (pounds)
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below **and** mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory ☐YES ☐NO
- ☐ A1. Anemia
- ☐ A2. Angina
- ☐ A3. Angioplasty/Stent
- ☐ A4. Aneurysm
- ☐ A5. Blood Clots
- ☐ A6. Blood Disorder
- ☐ A7. Bypass
- ☐ A8. Cardiac Arrhythmia
- ☐ A9. Chest Pain
- ☐ A10. Congestive Heart Failure
- ☐ A11. Coronary Heart Disease
- ☐ A12. Heart Murmur
- ☐ A13. Hemophilia
- ☐ A14. High/Low Blood Pressure
- ☐ A15. High Cholesterol
- ☐ A16. Pacemaker
- ☐ A17. Palpitations
- ☐ A18. Sickle Cell Anemia
- ☐ A19. Stroke/TIA
- ☐ A20. Varicose Veins
- ☐ A21. Ventricular Tachycardia
- ☐ A22. Other (_____)

B. Eyes/Ears/Nose/Throat ☐YES ☐NO
- ☐ B1. Acoustic Neuroma
- ☐ B2. Cataracts
- ☐ B3. Chronic Sinusitis
- ☐ B4. Cleft Lip/Palate
- ☐ B5. Detached Retina
- ☐ B6. Deviated Septum
- ☐ B7. Ear Infections
- ☐ B8. Glaucoma
- ☐ B9. Retinopathy
- ☐ B10. Other (_____)

C. Immune ☐YES ☐NO
- ☐ C1. ALS
- ☐ C2. AIDS
- ☐ C3. HIV+
- ☐ C4. Immuno Deficiency
- ☐ C5. Lupus
- ☐ C6. Psoriasis
- ☐ C7. Scleroderma
- ☐ C8. Other (_____)

D. Cancer/Tumors ☐YES ☐NO
- ☐ D1. Brain
- ☐ D2. Breast
- ☐ D3. Colon
- ☐ D4. Cyst
- ☐ D5. Hodgkin's Disease
- ☐ D6. Leukemia
- ☐ D7. Liver
- ☐ D8. Lung
- ☐ D9. Lymphoma
- ☐ D10. Melanoma
- ☐ D11. Ovarian
- ☐ D12. Pituitary
- ☐ D13. Prostate
- ☐ D14. Stomach
- ☐ D15. Testicular
- ☐ D16. Thyroid
- ☐ D17. Other (_____)
- ☐ D18. Stage of Cancer if known _____

E. Neurological ☐YES ☐NO
- ☐ E1. Alzheimer's Disease
- ☐ E2. Cerebral Palsy
- ☐ E3. Epilepsy
- ☐ E4. Head Injury
- ☐ E5. Migraines
- ☐ E6. Multiple Sclerosis
- ☐ E7. Neuritis
- ☐ E8. Paralysis/Hemiplegia
- ☐ E9. Parkinson's Disease
- ☐ E10. Seizures/Convulsions
- ☐ E11. Other (_____)

F. Transplants ☐YES ☐NO
- ☐ F1. Pending
- ☐ F2. On Waiting List
- ☐ F3. Completed Transplant
- ☐ F4. Bone Marrow
- ☐ F5. Stem Cell
- ☐ F6. Organ (Type: _____)

G. Arthritis ☐YES ☐NO
- ☐ G1. Arthritis
- ☐ G2. Osteoarthritis
- ☐ G3. Rheumatoid Arthritis
- ☐ G4. Other (_____)

H. Bones/Muscles/Joints ☐YES ☐NO
- ☐ H1. Bulging/Herniated Disk
- ☐ H2. Carpal Tunnel Syndrome
- ☐ H3. Fibromyalgia/CFS
- ☐ H4. Fractures (Open or Closed)
- ☐ H5. Gout
- ☐ H6. Joint Replacement(Type:_____)
- ☐ H7. Knee
- ☐ H8. Muscular Dystrophy
- ☐ H9. Neck/Back
- ☐ H10. Shoulder
- ☐ H11. Spina Bifida
- ☐ H12. Sprain/Strain
- ☐ H13. Other (_____)

I. Psychological ☐YES ☐NO
- ☐ I1. ADD/ADHD
- ☐ I2. Alcoholism
- ☐ I3. Anxiety
- ☐ I4. Autism
- ☐ I5. Bipolar
- ☐ I6. Depression
- ☐ I7. Drug Abuse
- ☐ I8. Eating Disorder
- ☐ I9. Schizophrenia
- ☐ I10. Suicide Attempt
- ☐ I11. Other (_____)

J. Diabetes/Endocrine ☐YES ☐NO
- ☐ J1. Diabetes controlled by:
  - ☐ a. Diet
  - ☐ b. Oral Medication
  - ☐ c. Insulin
  - ☐ d. Other (_____)
- ☐ J2. Adrenal Glands
- ☐ J3. Growth Hormones
- ☐ J4. Hyperthyroidism/Hypothyroidism
- ☐ J5. Other (_____)

K. Reproductive ☐YES ☐NO
- ☐ K1. Breast Disorder
- ☐ K2. Endometriosis
- ☐ K3. Fibroids
- ☐ K4. Menstrual Disorder
- ☐ K5. Ovarian Cysts
- ☐ K6. Other (_____)

L. Lung/Respiratory ☐YES ☐NO	M. Intestinal ☐YES ☐NO	N. Liver/Kidney/Urinary ☐YES ☐NO
☐ L1. Allergies	☐ M1. Acid Reflux/GERD	☐ N1. Bladder Disorder
☐ L2. Asthma	☐ M2. Colitis/IBS	☐ N2. Cirrhosis
☐ L3. COPD (On Oxygen? _____)	☐ M3. Colon Disorder	☐ N3. Gaucher's Disease
☐ L4. Cystic Fibrosis	☐ M4. Crohn's Disease	☐ N4. Hepatitis (Type: _____)
☐ L5. Emphysema	☐ M5. Diverticulitis/Diverticulum	☐ N5. Jaundice
☐ L6. Lung Disorder	☐ M6. Gallbladder	☐ N6. Kidney Disorder
☐ L7. Pneumonia	☐ M7. Gastric Bypass	☐ N7. Kidney Stones
☐ L8. Sarcoidosis	☐ M8. Hiatal Hernia/Reflux	☐ N8. Liver Disorder
☐ L9. Sleep Apnea	☐ M9. Pancreatitis	☐ N9. Polycystic Kidney
☐ L10. Tuberculosis	☐ M10. Ulcer	☐ N10. Prostate
☐ L11. Valley Fever	☐ M11. Ulcerative Colitis	☐ N11. Renal Failure
☐ L12. Other (_____)	☐ M12. Other (_____)	☐ N12. Other (_____)

Please answer the following questions for yourself and for anyone in your family applying for coverage:

1. ☐YES ☐NO Is anyone currently pregnant or an expectant parent?
   Due date: _____
   ☐Yes ☐No a. Has the pregnancy been confirmed by a physician or practitioner?
   ☐Yes ☐No b. Pregnancy complications?
   ☐Yes ☐No c. Multiple births expected?

2. ☐YES ☐NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?

3. ☐YES ☐NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?

4. ☐YES ☐NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?
   ☐ abnormal test or physical results ☐ pending test results
   ☐ health condition, illness or injury that may require treatment or surgery
   ☐ tests, treatment or surgery advised ☐ unexplained weight gain/loss or fatigue
   ☐ Worker's Compensation injury or illness ☐ condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

Section 3: Family Medications

☐ YES ☐ NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

Employee Signature: Print, sign and submit this form. Information that you entered on this form cannot be saved on your computer.

Date Signed: _____