



BERNIEFORMS HOW TO:

Implementation Tips and Tricks

BERNIEFORMS IMPLEMENTATION

TIPS & TRICKS

1 Step 1: Getting ready

Choose which carriers you plan to quote, and print off copies of the questionnaires for the producers and service team members most responsible for quoting those carriers.

2 Step 2: Team meeting - Deciding on which questions to ask and how to ask them

In the meeting, go through each carrier questionnaire to decide which questions need to be asked and how to pose each question. For example, you might adjust “Hours worked?” to “Average hours worked per week?”

PRO TIP:

In BernieForms, you are able to ask two types of custom questions - option questions (meaning those with multiple choice answers) and text questions (meaning those with answers that will be entered in an open-ended text field).

Example:

- Option Field Question: “What is your marital status?” Options: Single / Married / Widowed / Divorced
- Text Field Question: “What is your COBRA effective date (N/A if not applicable)?”

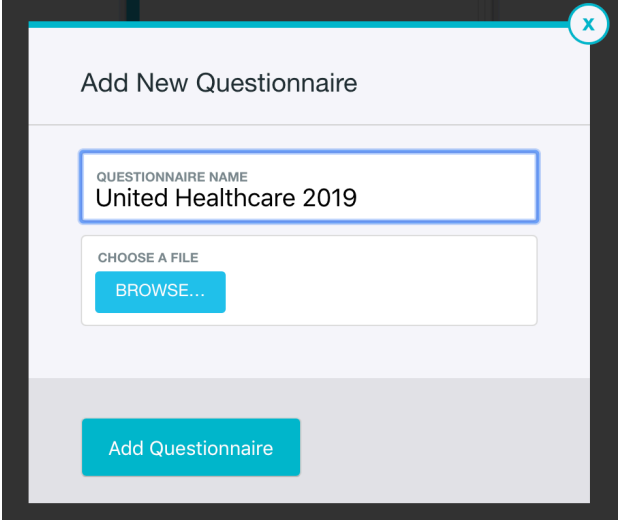
3 Step 3: Upload blank copies of the health questionnaires in BernieForms

In BernieForms, click on Questionnaire Library and then click on the “New Questionnaire” button. Upload and name each questionnaire. Make sure the questionnaires you upload are *not* encrypted. Find out how to [unencrypt your questionnaires here](#).

PRO TIP:

Reach out to each carrier you plan to quote and have them send you the newest, freshest digital copy of their carrier questionnaire. Do not scan and upload older questionnaires as they won't be as clear in BernieForms when you try to map them.

A large teal button with a white plus icon and the text “New Questionnaire”.

A screenshot of the “Add New Questionnaire” form in the BernieForms application. The form has a light gray background and a dark gray border. At the top right is a close button (X). The title “Add New Questionnaire” is centered at the top. Below the title is a text input field labeled “QUESTIONNAIRE NAME” containing the text “United Healthcare 2019”. Below that is a section labeled “CHOOSE A FILE” with a “BROWSE...” button. At the bottom is a large teal button labeled “Add Questionnaire”.

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Step 4: Add all fields to BernieForms that you plan to use on health questionnaires

Click to open one of the health questionnaires that you have just uploaded. You'll see on the left hand side that you have the ability to add fields by selecting + New Field. Starting with the longest health questionnaire first, go through and add every checkable health condition that appears on the questionnaire.

Then, do the same for the rest of the questionnaires. You do not have to add duplicate health conditions as they will carry over from questionnaire to questionnaire (and be automatically alphabetized).

Now, do the same for all custom questions that your team composed in the meeting.

PRO TIP:

The custom questions will appear to employees at the "Other" stage of the process in the same order they appear in the left-hand pane. So be sure to think through the order which you would like the questions to be posed to employees, ideally during your initial team meeting, then drag & drop them accordingly.

Custom Fields

What is your marital status?

Are you or your spouse currently enrolled in Medicare Parts A, B, or D?

What is your height?

Who is your spouse's employer?

Have medications been prescribed in the past 18 months for you / any dependents?

Are you or any dependent(s) disabled?

If you or your spouse are covered under Medicare, for whom? (Write N/A if applicable)

+ TEXT FIELD

+ OPTION FIELD

Health Conditions

AIDS / HIV / Immune System Disorder

Alcohol / Drug Abuse

Allergies

Alzheimer's

Anorexia or Bulimia

Arthritis

Arthritis, Back, Bone, Joint Disorder

Asthma

Atrial Fibrillation (Irregular Heartbeat)

Auto-Immune Disorders

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5 Step 5: Map the questionnaires

Now you are ready to map your questionnaires. Open each questionnaire and drag and drop each field from the left-hand pane to where you want it to appear on the questionnaire.

PRO TIP:

You'll want to map every health condition on top of the Yes check box on the questionnaire.

Employee				<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse				<input type="checkbox"/> Yes <input type="checkbox"/> No

Complete all questions below and check all that apply in Question 1. Complete Section G on the next page by providing complete details for each Yes answer and for all conditions checked in Question 1.

1. Have you or any of your dependents included on this enrollment form within the past 5 years received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following?..... ☐ Yes ☐ No

22	<input type="checkbox"/> AIDS or HIV	28	<input type="checkbox"/> Fertility Disorders
23	<input type="checkbox"/> Alcohol or Drug Use, Abuse, or Dependency	29	<input type="checkbox"/> Eye Injury or Disorder
	<input type="checkbox"/> Arthritis or other Skeletal Disorder		<input type="checkbox"/> Gallbladder/Hepatitis
	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid	31	<input type="checkbox"/> Hepatitis B
	<input type="checkbox"/> Other		<input type="checkbox"/> Hepatitis D
24	<input type="checkbox"/> Back Disorders	32	<input type="checkbox"/> Hepatitis C
	<input type="checkbox"/> Chiropractic <input type="checkbox"/> Sprain/strain		<input type="checkbox"/> Other
	<input type="checkbox"/> Surgery <input type="checkbox"/> Other		
3	<input type="checkbox"/> Blood Disorders (including anemia)	7	<input type="checkbox"/> Discoid
	<input type="checkbox"/> Cancer or Tumor; Stage _____		<input type="checkbox"/> Systemic Lupus Erythematosus
	<input type="checkbox"/> Local (confined to the organ where it began)	30	<input type="checkbox"/> Mental, Nervous or Behavioral Disorder
	<input type="checkbox"/> Regional (spread to nearby lymph nodes/organs)		<input type="checkbox"/> Inpatient Treatment <input type="checkbox"/> Outpatient Treatment
	<input type="checkbox"/> Distant/Metastasis (spread to distant organs)	33	<input type="checkbox"/> ADHD/ADD <input type="checkbox"/> Anxiety
4	<input type="checkbox"/> Chest Pain		<input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Depression
	<input type="checkbox"/> Diabetes Mellitus Date of onset ____/____/____		<input type="checkbox"/> Other
	<input type="checkbox"/> Pre-Diabetes <input type="checkbox"/> Diet Controlled		<input type="checkbox"/> Migraine or Chronic Headache
	<input type="checkbox"/> Type I <input type="checkbox"/> Type II		<input type="checkbox"/> Multiple Sclerosis (MS)
25	<input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Insulin Pump		<input type="checkbox"/> Muscle Disorders
	<input type="checkbox"/> Endocrine Related Disorders		<input type="checkbox"/> Nervous System Disorders
	<input type="checkbox"/> Heart disease <input type="checkbox"/> Nephropathy		<input type="checkbox"/> Paralysis
	<input type="checkbox"/> Neuropathy <input type="checkbox"/> Peripheral Vascular Disease		<input type="checkbox"/> Partial or Total Disability
			<input type="checkbox"/> Physical Disorder or Deformity

PRO TIP:

BernieForms automatically collects additional follow-up information about dependents and health conditions from the employee throughout the process, so you won't need to do anything beyond dragging and dropping a rectangle box over the relevant dependent or health condition table.

SECTION 4: DEPENDENT INFORMATION (Please complete for all participating dependents. Attach additional sheets if necessary)							
First Name	Last Name	Relationship (Spouse, Son, Daughter)	Social Security # (Required if Enrolling)	DOB (mm/dd/yyyy)	Age	M / F	Tobacco Use YES / NO
See dependent table (attached)							

SECTION 5: PLAN PARTICIPATION	
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PRO TIP:

For option questions, you'll be asked to map each potential answer over the relevant box on the questionnaire (for example - [Single] [Divorced] [Married] and [Widowed] all get separate boxes to map).

		<input type="checkbox"/> Male	<input type="checkbox"/> Female			<input type="checkbox"/> Yes	<input type="checkbox"/> No
Marital Status:		<input type="text" value="Single"/>	<input type="text" value="Divorced"/>	<input type="text" value="Married"/>	<input type="text" value="Widowed"/>		
Home Phone		Cell Phone		Email Address			
Job Title				Hours Worked Per Week (Required in Enrolling)			
Spouse's Employer				Spouse's Business Phone			
SECTION 3: OTHER INSURANCE COVERAGE							
Are you or any dependent(s) disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes, please indicate name(s):							
Do you, your spouse or dependents have other health insurance coverage that will continue in addition to this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No							
If Yes, name of Carrier:							
Policy Holder's Name:				Policy #		Effective Date	
Name(s) of Covered Dependents:							
SECTION 4: DEPENDENT INFORMATION (Please complete for all participating dependents. Attach additional sheets if necessary)							
First Name	Last Name	Relationship (Spouse, Son, Daughter)	Social Security # (Required if Enrolling)	DOB (mm/dd/yyyy)	Age	M / F	Tobacco Use YES / NO

PLACE

CANCEL