FORTEGRA®
BENEFITS

Complete Form in its entirety - either via fillable pdf, or print and complete by hand

FINAL DOC to be submitted to johnk@fortegra.com

Group Health Questionnaire

This questionnaire must be filled out completely. Please be sure to indicate "**None**" if applicable.
Outfront Health will not accept the questionnaire if incomplete. Use additional paper if necessary.

Today's Date

Requested Effective Date:

COMPANY AND CURRENT ENROLLMENT INFORMATION

Company Name

Street Address

City

State

County

Zip Code

Benefits Contact Name

Email

Total Number of Employees

Total Full Time

Total Part Time

Total Currently Enrolled In Medical Benefit Plan

Are any health plan enrollees NOT paid employees (other than spouses or children)? Yes No
***If yes, please provide name, address, date of birth, reason for coverage:

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 an Association? Yes No

Any ineligible class of employees? Yes No

If yes, name of the Assoc:

If yes, which class?

Please provide a complete description of your business operation

SIC Code

Number of Locations

Please identify all states of operation

Group Health Questionnaire

List any <u>current participants</u> in COBRA / State Continuation (use additional paper if necessary)

NONE

Name of Individual	COBRA/Continuation Effective Date	Activating Event

List any participants currently <u>eligible</u> 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 (use additional paper if necessary)

NONE

Name of Individual	Date Eligible	Activating Event

List any enrolled employees and/or dependents currently on FMLA, Work Comp or Disability Leave.

NONE

Name of Individual	Type of Leave	Expected date of Return

Group Health Questionnaire

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:

To the Best of My Knowledge (any or all)

Question		
Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?	Yes	No
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
Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	Yes	No

If yes, to any or all, please provide details in table below

SPECIFIC ILLNESS QUESTION

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

To the Best of My Knowledge (any or all)

AIDS or testing HIV Positive	Kidney Disorder	Stroke
Arthritis	Liver Disease	Substance Dependency
Back Disorder	Mental Illness	Organ Transplant
Cancer (other than skin)	Muscular Disorder	Tumor
Diabetes	Nervous System Disorders	
Heart Disease	Respiratory Disease	Other Serious Conditions

If any boxes are checked, please provide details in the table below

Name	Gender (M or F)	Date of Birth	Condition	Date Last Treated	Treatment/Drug	% Degree of Recovery

Group Health Questionnaire

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	Due Date	Type of Pregnancy or Condition (normal, highrisk, preterm labor, etc)

I certify that the statements herein are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage. I will notify the entity collecting this information of any changes that occur after signing this Group Health Questionnaire and prior to implementing health coverage.

In the event that material information has been omitted or is inaccurate, the service agreement may be terminated for breach. In such cases, my company may be liable to OutFront Health or an employee for damages.

This information is gathered 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.

In compliance with requirements for GINA, the entity collecting this information is not requesting genetic information. No information regarding the height or weight of any employee has been provided.

Name of Preparer Title Date

Preparer Phone Number (Required)

Preparer Email Address Print Name of Company

Broker/Sales Signature Broker/Sales Print Name Date

Client Privacy Notification

Thank you for completing the requested information above. Any non-public person information (i.e. Name with address and/or social security number, and detail health information (protected health information) that you provide via hard copy or through the OutFront Health Form FIre Secure Online Employee Health Application System 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. OutFront Health is acting as a Business Associate to the PEO/MEWA/Association/Trust and is subject to certain provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPPA) regulations.OutFront Health will not sell, license, transmit or disclose this information outside of OutFront Health unless: a) necessary to provide the 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.