Aetna Group Questionnaire

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children).

IMPORTANT: Your answers to these questions must include all COBRA and State Continued individuals covered by your present plan.

[ ] Yes [ ] No A. Are any employees, dependents or COBRA continuees considered disabled?

[ ] Yes [ ] No B. Are any employees or dependents contemplating treatment or hospitalization, being advised to seek treatment, or being scheduled for hospitalization and/or surgery?

[ ] Yes [ ] No C. Are any employees or dependents pregnant? If yes, how many? _______________

[ ] Yes [ ] No D. Has any employee missed 10 or more consecutive days of work in the last 12 months due to injury or illness?

[ ] Yes [ ] No E. Has the Group or Broker/Agent requested and/or received paid claim information within the past 6 months from your current carrier? If yes, please provide all claim information received.

[ ] Yes [ ] No F. Within the past 12 months, has any employee or dependents had a serious continuing claim (i.e., chronic or ongoing condition likely to cost $10,000 or more per year for treatment) due to a mental or physical disorder? If yes, check the appropriate box(es) below.

[ ] AIDS / Immune Disorders	[ ] Cardiovascular	[ ] Infertility	[ ] Neurological
[ ] Alcohol Abuse	[ ] Diabetes	[ ] Intestines	[ ] Pancreas
[ ] Arthritis	[ ] Drug / Substance Abuse	[ ] Kidney	[ ] Skin
[ ] Back, Neck	[ ] Epilepsy	[ ] Liver	[ ] Stomach
[ ] Blood	[ ] Ears / Eyes	[ ] Lungs	[ ] Stroke / Paralysis
[ ] Bone / Joint	[ ] Emphysema / Pulmonary	[ ] Lupus	[ ] Venereal
[ ] Brain	[ ] Heart Disease	[ ] Mental / Nervous	[ ] Other (detail below)
[ ] Cancer / Tumor	[ ] High Risk Pregnancies	[ ] Migraines	

If you answered "Yes" to question B, C, D or F, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep	Age	Site Location	Nature of Condition	Dates of Treatment	Names of Medication	$ Amount of Prior Claims	Current Status

Aetna will rely on the information provided to determine whether a proposal will be issued. The responses are assumed to be correct. If errors or omissions are subsequently found, Aetna reserves the right to revise rates or rescind the quote.

Prospective Applicant Name and Title (Please Print) Prospective Applicant Signature Date

Agent Signature (Existing?: ☐ Yes, ☐ No) Date Sales Representative Signature Date

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