GROUP QUESTIONNAIRE

SUPPLEMENT TO GROUP APPLICATION FOR

MCMS, INC. INSURANCE TRUST

Your E-Mail Address: _____

I. GENERAL INFORMATION

Name of Medical Practice_____ **Group Health Plan Anniversary Date** _____

Mailing Address _____**City**_____ **State**_____ **Zip Code**_____

Contact Person _____ **Phone** _____

II. GROUP ABSTRACT

1. Are you an employer with full-time employees? □ Yes □ No

2. Number of eligible full-time employees _____ What is your current Waiting Period? **0 / 30 / 60 days**

3. How many full-time employees are covered by another employer plan? _____

4. Number of Employees/Dependents on COBRA Continuation _____(provide details in Section IV).

5. Name of Current Agent _____ Name of Agency _____

6. Current Health Insurance Carrier _____ Group #_____

7. Employer Contribution _____% of Employee Premium; _____ % of Dependent Premium.

*Attach Current Group Census **(Please Notate all Physician Owner/Partners)**
*Attach Current Group Health Insurance Billing Statement
*Attach Current Group Health Benefit(s)
*Attach Latest RT-6

III. GROUP MEDICAL HISTORY

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). Do not indicate any person's name, Social Security Number, or title. This information will be used to evaluate medical risk, not eligibility for individual coverage. The Health Insurance Portability and Accountability Act ("HIPAA") prohibits group health insurance issuers from establishing rules for eligibility on the basis of health factors. Health factors are defined as: health status; medical condition; claims experience; receipt of health care; medical history; genetic information; evidence of insurability, and disability.

Please Complete Both Pages & Return to Barrett, Liner & Buss, LLC

E-mail: info@trustmcmstrust.com
Fax: (352) 622-1050
Mail:
Barrett, Liner & Buss, LLC
PO Box 270
Ocala, Florida 34478-0270

Over Please ►

□ Yes □ No 1. Within the past 12 months have any employees or their dependents told you that he/she or a dependent has been diagnosed or treated for any of the conditions below? Please check the appropriate box(es).

□ ARC or AIDS	□ Diabetes	□ Immune System	□ Neurological
□ Alcohol Abuse	□ Drug/Substance Abuse	□ Infertility	□ Pancreas
□ Arthritis	□ Enlarged Lymph Nodes	□ Intestines	□ Skin
□ Back, Neck	□ Epilepsy	□ Kidneys	□ Stomach
□ Blood	□ Ears/Eyes	□ Liver	□ Stroke/Paralysis
□ Bone/Joint	□ Emphysema/Pulmonary	□ Lungs	□ Transplants
□ Brain	□ Growth Disorders	□ Lupus	□ Vascular Disease
□ Cancer/Tumor	□ Heart Disease	□ Mental/Nervous	□ Venereal
□ Cardiovascular	□ High Risk Pregnancies	□ Migraines	□ Other, Detail Below

□ Yes □ No 2. To your knowledge, within the last 12 months has any employee or their eligible dependent been hospitalized?

□ Yes □ No 3. Have any employees or dependents told you that he/she or a dependent will undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months?

□ Yes □ No 4. Within the last 12 months, has any employee or their eligible dependent probably had medical claims in excess of $10,000?

□ Yes □ No 5. Are any covered employees or their dependents currently receiving any Injectibles, Specialty Drugs, or Infusion Therapy?

If you answered "Yes" to any of the medical questions, please complete the following or attach a page for additional space:

Question #	Illness and Medication	Year of Treatment

IV. ADDITIONAL INFORMATION

COBRA CONTINUANCE

Provide details on type of qualifying event and expiration date of each person entitled to COBRA continuance.

_____

_____

The undersigned Company Officer* hereby acknowledges that: (1) the information set out in this Underwriting Questionnaire will be relied on by Blue Cross and Blue Shield of Florida, Inc./Health Options, Inc.; (2) this information is complete, truthful and correct; (3) to the best of my knowledge no information has been withheld or omitted concerning the past and present state of health of eligible employees and their dependents applying for this coverage and; (4) the summary health information set out in this Underwriting Questionnaire was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

_____ _____

Print Name of Authorized Company Officer* Signature of Authorized Company Officer*

_____ _____

Date Title of Officer

*Company's Human Resource and/or Employee Benefits Officer