



Mid-Atlantic Region Group Underwriting Questionnaire

Prospect Name: _____
 Address: _____
 Producer Name: _____
 Producer Firm/Address: _____
 Type of Industry: _____
 Aetna Representative: **Attracta Mulkerrin** email- mulkerrina@aetna.com

Effective Date: _____
 SIC Code: _____
 Producer Phone: _____
 Producer Fax: _____
 Vendor Number: _____
 Phone 412-369-4915 Fax 412-875-7861

Plan Information

- 1) Is there a group plan currently in place? Yes _____ If yes, supply group number: _____
- 2) Please identify the current carrier(s), plan type, current rates and last rate increase:
 (Please include copy of current paid invoice)

Carrier Name	Plan Type	EE	EE/ Spouse	EE/Child	EE/Family	Last Rate Increase %
		\$	\$	\$	\$	%
		\$	\$	\$	\$	%
		\$	\$	\$	\$	%

- 3) Please identify employer **monthly** contributions: EE: _____ EE/ Spouse: _____ EE/Child _____ EE/Family _____
- 4) Are employer contributions the same for all employees? _____
 If "No", please explain: _____
- 5) What types of AETNA medical plan options will be offered:

HMO <input type="checkbox"/>	Open Access HMO <input type="checkbox"/>	POS <input type="checkbox"/>	Open Access POS <input type="checkbox"/>	PPO <input type="checkbox"/>	Dental <input type="checkbox"/>	Life <input type="checkbox"/>	If "Other", please describe _____
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- 6) If Aetna will be an option, what other carriers/plans will be offered?

Carrier: _____	Plan Type: _____	Carrier: _____	Plan Type: _____
Carrier: _____	Plan Type: _____	Carrier: _____	Plan Type: _____

Prospective Group Information

- 1) Total number of eligible active employees: _____ (Please include most recent census and UC-2 Form)
- 2) How many active employees are enrolled in the current plan(s)? _____
- 3) How many eligible employees, not on the company sponsored plan, have spousal coverage? _____
- 4) Current number of COBRA Continuees enrolled in current plan: _____
- 5) Are union employees covered under the plan? _____ If yes, please identify union name/type.: _____
- 6) What classes of employees are eligible for employer coverage? Full Time Part Time
 Other, explain: _____
 If part time are eligible, are employer contributions the same as full time employees? _____
 If No, please provide employer contributions: EE: _____ EE/Spouse: _____ EE/Child _____ EE /Family _____
- 7) Do all eligible employees work 25 or more hours per week on a regularly scheduled basis?
 If "No", please explain: _____
- 8) Are early Retirees <65 eligible for coverage?
 If yes, how many are covered? _____ Are they offered the same benefits as full time? _____
 If "No", describe benefits: _____
- 9) Are Retirees >65 eligible for coverage? _____
 Are they offered the same benefits as full time? _____ If No, describe benefits: _____
- 10) Does the company currently offer Workers Compensation coverage? _____
- 11) Current Benefit Waiting Period: _____

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.

<input type="checkbox"/> AIDS / Immune Disorders	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Infertility	<input type="checkbox"/> Neurological
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Intestines	<input type="checkbox"/> Pancreas
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug / Substance Abuse	<input type="checkbox"/> Kidney	<input type="checkbox"/> Skin
<input type="checkbox"/> Back, Neck	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver	<input type="checkbox"/> Stomach
<input type="checkbox"/> Blood	<input type="checkbox"/> Ears / Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Stroke / Paralysis
<input type="checkbox"/> Bone / Joint	<input type="checkbox"/> Emphysema / Pulmonary	<input type="checkbox"/> Lupus	<input type="checkbox"/> Venereal
<input type="checkbox"/> Brain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental / Nervous	<input type="checkbox"/> Other (detail below)
<input type="checkbox"/> Cancer / Tumor	<input type="checkbox"/> High Risk Pregnancies	<input type="checkbox"/> 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?: <input type="checkbox"/> Yes, <input type="checkbox"/> No) Date	Sales Representative Signature	Date

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