tda Tennessee DENTAL ASSOCIATION

GROUP EMPLOYER QUESTIONNAIRE

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

Date______________________ Proposed Effective Date: _____________

COMPANY AND CURRENT ENROLLMENT INFORMATION

Company Name Street Address		
City	State	Zip
County	Benefits Contact: Contact Phone# Email Address:	
Total Number of Employees on Payroll:	Total Full Time: Total Part Time:	Total Number of Employees currently enrolled in health care plan:
Are any health care plan enrollees NOT paid Employees? (other than eligible dependents - spouses/children) *If yes, please provide names and details	Yes	No
Current Health Carrier:	Health Carrier Renewal Date:	
Is your currently plan self-funded: Yes No Unknown *If yes, please provide claims.		
If your currently with a PEO? Yes No *If yes, name of PEO	Do you have any ineligible class of employees? Yes No *If yes, which class?	
Please provide a complete description of your business operations:	SIC Code:	
Number of Locations:	Identify all states of operations:	

GROUP EMPLOYER QUESTIONNAIRE

A. **List any current participants in COBRA / State Continuation.**

NONE

Name of Individual	COBRA / Continuation Effective Date	Triggering Reason and Date

B. List any participants currently eligible 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.

NONE

Name of Individual	COBRA / Continuation Eligibility Date	Triggering Reason and Date

C. List any employees and/or dependents who are on the health plan that are disabled.

NONE

Name of Individual	Disability	Qualifying Event

GROUP EMPLOYER QUESTIONNAIRE

RATE HISTORY (if more than 3 plans being offered, please provide information for 3 mostly popular plans)

Plan 1 Name:	# Enrolled:	Renewal Rates (eff.)	Most recent 12 months	13-24 months prior
Employee Only				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

Plan 2 Name:	# Enrolled:	Renewal Rates (eff.)	Most recent 12 months	13-24 months prior
Employee Only				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

Plan 3 Name:	# Enrolled:	Renewal Rates (eff.)	Most recent 12 months	13-24 months prior
Employee Only				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

CURRENT PLAN BENEFIT SUMMARY INFORMATION (Individual, In-Network Only)

Current Plan Name	1:			2:			3:		
Current Plan Types:	HMO PPO HDHP POS			HMO PPO HDHP POS			HMO PPO HDHP POS		
Annual Deductible									
Coinsurance (as %)									
Out-of-Pocket Max									
Office Visit Copay									
Prescription Drug Copay or Coinsurance Generic | Brand Formulary | Brand Non-Formulary									

CURRENT PLAN CONTRIBUTION INFORMATION

	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels (by $ or %)				

GROUP EMPLOYER QUESTIONNAIRE

I certify that the statements 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 Plan of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with The Plan.

In the event that material information has been omitted or is inaccurate, the insurance carrier may deny, limit or retroactively terminate coverage back to the coverage inception date. Furthermore, The Plan service agreement may also terminate for breach of contract resulting from the material misrepresentation. In such cases. I understand that The Plan also may adjust my insurance premiums to properly reflect the underwriting risk present at the time of the original misrepresentation.

The Plan gathers this information 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. Prospective employees in Michigan should not provide information regarding height or weight.

The Plan Notice of Privacy Practices provides more detailed information about how The Plan and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practice s before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The Plan and my health plan are not required by law to grant my request However, if my request is granted, The Plan and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent The Plan or my health plan have already used or disclosed my protected health information in reliance upon my consent.

Information disclosed on this form is considered valid for effective dates within 90 days of date signed. I will notify The Plan of any changes that occur after signing this Group Major Illness Questionnaire and prior to starting health coverage with The Plan. I understand that The Plan reserves the right to re-underwrite based on a change in the Census or Demographics.

Authorized Signature	Title	Date
Print Name	Print Name of Company	
Broker / Sales - Signature	Broker / Sales – Print	Date