

AiGA Group Benefit Qualifying Questionnaire

CONFIDENTIAL QUESTIONNAIRE

Thank you for expressing an interest in participating in future AiGA-sponsored member benefits!

As a new association without prior group medical history, we are being asked to submit the following questionnaire to qualify AiGA for group health benefits. This information is necessary in order to bid our proposal to insurance carriers so we can obtain the best terms and affordable rates for you. Please note that the questionnaire is designed for underwriting purposes. Your name is not necessary.

Please submit your completed questionnaire and requested information by **December 1, 2007**. Failure to receive a sufficient, timely response will delay our bidding and underwriting process for a 2008 benefit. All information will be aggregated and kept strictly confidential.

Please contact AiGA at 817-509-0480 if you have any questions. Thank you!

PART ONE

SECTION A. PERSON APPLYING FOR COVERAGE <i>(Please print.)</i>				
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (MM/DD/YY)	Home Zip Code		
Job Title	Annual Salary	Date of Hire (YYYY/MM/DD) or Business Ownership		
Work Status:	<input type="checkbox"/> New Hire	<input type="checkbox"/> Active	<input type="checkbox"/> Retired	<input type="checkbox"/> COBRA
	<input type="checkbox"/> Rehire	<input type="checkbox"/> On Layoff/Leave of Absence	<input type="checkbox"/> Disabled	SIC Code

Spouse and dependent CHILDREN you wish to cover (dependent children must be under age 25 and unmarried).

Dependents	Relation (spouse or child)	Home Zip Code	Sex	Date of Birth (MM/DD/YY)
#1			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#2			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#3			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#4			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#5			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#6			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#7			<input type="checkbox"/> Male <input type="checkbox"/> Female	

#8			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#9			<input type="checkbox"/> Male <input type="checkbox"/> Female	
#10			<input type="checkbox"/> Male <input type="checkbox"/> Female	

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PART TWO – Health/Medical History

All health history/medical questions must be completed for all individuals (including dependents). If you answer "Yes" to ANY questions in this section, please give details on the following page. Please note the timeframe reference for each question.

SECTION A. HEALTH HISTORY/MEDICAL QUESTIONS	
1. Has any person applying for coverage been advised, counseled, tested, diagnosed, treated, hospitalized or recommended for treatment within the last 10 years ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. During the last 5 years , has any person applying for coverage had a physical examination (including check-ups), diagnostic tests, consulted a physician, chiropractor or therapist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did any of the occurrences mentioned above (in item #1 and item #2) result in costs exceeding \$10,000?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If you answered "Yes", what was the cause for the cost/claim exceeding \$10,000? _____	
4. Question for Females and Dependents Only: Is any female that would be considered for coverage now pregnant? . . .	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Question for Males and Dependents Only: Is any male that would be considered for coverage now an expectant parent? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to ANY questions in the section above, please provide further information using the chart below. Be sure to use the "correct example" as your guide. Please insert another page if you need additional space. This information should include information for the primary insured as well as eligible dependents for coverage.

SECTION B. DETAILS OF HEALTH HISTORY							
	Question Number	Person Affected	Condition, Injury, Symptom, or Diagnosis			Was Recovery Complete?	Type of Treatment, Advice Given and Medications Prescribed
			What is it?	Date that it started	Date of Recovery (if applicable)		
Correct Example	1	Self	Hypothyroid	7/86	none	no, ongoing	Synthroid 0.05mg once/day

Current and Previous Coverage Information
Please provide coverage information for the last 24 months for you and any eligible dependents listed. If you have a certificate of current or prior coverage, please attach a copy to this application. (If more than one plan was in effect, attach additional pages.) Also, please attach a current billing statement.

Current Health Coverage	Gender of Primary Policyholder <input type="checkbox"/> Male <input type="checkbox"/> Female	Number of years with current insurance carrier?	Is your employer contributing to your coverage? If yes, premium amount you are paying per month? OR, if you have purchased the coverage individually, what is the premium amount you pay per month?
	Employer's Name Employer's Address	Effective Date ___/___/_____ Do you intend to continue coverage if AiGA sponsors quality group insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employer-sponsored OR <input type="checkbox"/> Individual Purchase

Previous Health Coverage	Gender of Primary Policyholder <input type="checkbox"/> Male <input type="checkbox"/> Female	Number of years with previous insurance carrier?	Did your employer contribute to your coverage? If yes, premium amount you paid per month? OR, if you purchased the coverage individually, what was the premium amount you pay or paid per month?
	Employer's Name Employer's Address	Effective Date ___/___/_____ Do you still have coverage with this insurance carrier? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Coverage <input type="checkbox"/> Health <input type="checkbox"/> Dental <input type="checkbox"/> Employer-sponsored OR <input type="checkbox"/> Individual Purchase

As a new association without prior group medical history, we have been requested to submit this questionnaire and attach a number of documents to it. The additional documents include: (a) your current benefits booklet or schedule of coverage and (b) a current health insurance billing statement. Although we know this may present an inconvenience to you, these items are essential to put our group health insurance proposal out for bid. **All personal information, i.e. names, SS#, etc., must be blacked-out.** Please call AiGA at 817-509-0480 if you need assistance or have additional questions.

We appreciate the courtesy of your response by **December 1, 2007** by mail to the address below or through the AiGA Web site.

AiGA Association of Independent General Agents
 Post Office Box 212003
 Bedford, Texas 76095

AiGA www.AiGA.net

Thank you!