Powered by DecisionHR

Coverage Effective Date ____________

PEO Questionnaire (page 1 of 5)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. Decision HR will not accept the questionnaire if incomplete.

Date __________________ Proposed Effective Date: __________________

<table>
<tr><th colspan="6">I. COMPANY AND CURRENT ENROLLMENT INFORMATION</th></tr>
<tr><td>Company Name</td><td colspan="5"></td></tr>
<tr><td>Street Address</td><td colspan="5"></td></tr>
<tr><td>City & State</td><td></td><td>Zip</td><td></td><td>FEIN</td><td></td></tr>
<tr><td>County</td><td></td><td colspan="2">Benefits Contact & Phone #</td><td colspan="2"></td></tr>
<tr><td colspan="2">Total Number of employees on payroll:</td><td colspan="2">Total Full Time:
Total Part Time:</td><td colspan="2">Total Number of employees currently enrolled in health care plan:</td></tr>
<tr><td colspan="3">Current Health Carrier:
Years with Current Carrier:</td><td colspan="3">Health Carrier Renewal Date: _____/_____/______
Renewal Rates Received? ☐ Yes ☐ No</td></tr>
<tr><td colspan="6">Is Claims Experience available for your group? ☐ Yes (provide reports) ☐ No</td></tr>
<tr><td colspan="6">Is your current Plan Self-Funded? ☐ Yes ☐ No ☐ Don't Know ***If yes, please provide claims.</td></tr>
<tr><td colspan="3">Are you currently with a PEO? ☐ Yes ☐ No
If yes, name of PEO:</td><td colspan="3">Does your Company currently have a Wellness Program in place? ☐ Yes (attach details) ☐ No</td></tr>
<tr><td colspan="3">Please provide a description of your business operation:</td><td colspan="3">Does your Company currently have a Smoking or Tobacco Cessation program in place? ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Number of Locations: _______</td><td colspan="4">Please identify all states of operation: ____________________</td></tr>
<tr><td colspan="6">Are any health plan enrollees NOT paid employees (other than spouses or children)? ☐ Yes ☐ No</td></tr>
</table>

A. List any current COBRA / State Continuation participants: ❑ ***NONE***

Name / DOB / Phone # of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)

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 / DOB / Phone # of Individual	Date Eligible	Activating Event/Date

PEO Questionnaire (page 2 of 5)

II. CURRENT HEALTH PLAN EMPLOYER CONTRIBUTION INFORMATION *(Does your company have more than one Contribution Level? If so, please list each separately)*				
	Employee Only	Employee + Spouse	Employee + Child	Family
Company Contribution Levels ($ or %)				
Company Contribution Levels ($ or %)				

III. RATE HISTORY & PLAN DESIGN DETAILS (include the 3 most elected plans)

Plan 1 Name:______	**# Enrolled** ______	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ ______
Employee + Spouse	#	$	$	Co-Insurance % ______
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ ______ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ ______ Prescription Drugs___/___/____

Plan 2 Name:______	**# Enrolled** ______	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ ______
Employee + Spouse	#	$	$	Co-Insurance % ______
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ ______ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ ______ Prescription Drugs___/___/____

Plan 3 Name:______	**# Enrolled** ______	**Renewal Rates (eff.__/__/____)**	**Current Rates (eff.__/__/____)**	☐ HMO ☐ PPO ☐ HDHP ☐ POS ☐ ______
Enrollment		***Premium Rates or Total Premiums***		***Plan Design Details***
Employee Only	#	$	$	Annual Deductible $ ______
Employee + Spouse	#	$	$	Co-Insurance % ______
Employee + Child(ren)	#	$	$	Out of-Pocket Max$ ______ (excluding ded.)
Employee + Family	#	$	$	PCP Copay $ ______ Prescription Drugs___/___/____

- **Attach a copy of your benefit & billing summary for each plan and year listed above.**
- **Include carrier claims report if available.**

Next, please answer the following questions on behalf of your company <u>to the best of your knowledge</u>. This information will help determine if your group is best served by the implementation of a wellness program, as part of the Affordable Care Act.

IV. WELLNESS PROGRAM IMPACT APPRAISAL

Question	To the Best of My Knowledge
A. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?	❑ YES ❑ NO
B. Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?	❑ YES ❑ NO
C. Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	❑ YES ❑ NO

(If yes to any, please provide details in the table below.)

D. If anyone is currently being treated or been advised to seek treatment for any of the following, **please check all that apply:**

- ❑ AIDS or testing HIV Positive
- ❑ arthritis
- ❑ back disorder
- ❑ cancer
- ❑ diabetes
- ❑ heart disease
- ❑ kidney disorder
- ❑ liver disease
- ❑ mental illness
- ❑ muscular disorder
- ❑ nervous system disorde
- ❑ respiratory disease
- ❑ stroke
- ❑ substance dependency
- ❑ transplants
- ❑ tumor
- ❑ other serious conditions

(For all checked boxes, please provide details below)

Name **(Optional)**	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

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

❑ NONE

Name	Disability	Qualifying Event

Is Anyone Currently Pregnant? If yes, please provide due date and note below if **normal, high risk, multiple birth**, or **preterm labor** with this pregnancy. *This includes employees, dependents or COBRA participants.*		To the Best of My Knowledge: ❑ YES ❑ NO
Name **(Optional)**	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

The undersigned attests that the information is true and correct to the best of their knowledge. Authorization is provided to Decision HR to verify any of the information herein. The undersigned confirms that this is a Request for Proposal. This is not a contract for service with Decision HR. Any service provided will require a separate contract of service.

Authorized Signature _______________ **Title** _______________ **Date** _______________

Print Name _______________ **Print Name of Company** _______________

Broker / Sales Signature _______________ **Broker / Sales Print Name** _______________ **Date** _______________

DecisionHR

Required Documentation **Checklist**

Client Name:

State: Quote: BCBS Humana

Requested Effective Date: Commission:

In order to complete the following Request for Proposal, we will need the required documents requested below.

General Health Questionnaire (GHQ)

PEOV Required Employee Dependent Level Census Information

Include all employees: Full-time, Part-time, and COBRA - This should include any Non-Payroll health members as well

Plan Summaries

Plan summaries with rates (plan verticals)

SBCs

Rates

Current Rates **(A Prior carrier or PEO renewal with plans and rates or need invoices, or benefit registry)**

Renewal Rates **(with a PEO need renewal within 90 days of plan renewal) (Non-PEO within 60 days of plan renewal)**

Invoices

Medical Plan Invoices

Self Funded Plans

2 - 3 Years of Claims History (if only self-funded for 1 year, please provide prior proof of fully insured)

Trigger reports for Stop Loss