BATC EMPLOYER QUESTIONNAIRE

Company name: _____

Company address: _____

City, State, Zip: _____

Primary SIC Code: _____

Tax identification number: _____

Decision maker's name: _____

Direct phone number: _____

Email address: _____

Total number of eligible full-time employees: _____

Approximate number of employees requesting coverage: _____

Approximate number of employees out of state, by state: _____

Employer premium contribution: Single: $_____ Family: $ _____

Employer sponsored: ☐ HSA ☐ HRA ☐ VEBA ☐ 105

Single contributions: $_____ Family contributions: $ _____

1. Are any employees or dependents currently covered by your group health plan currently disabled or hospitalized?
   ☐ YES ☐ NO ☐ UNKNOWN

   If yes, please provide the following information:

Reason for disability or hospitalization	Begin date	End date	Estimated cost

2. Have any members covered by your health plan had claims over $25,000 in the past two years?
   ☐ YES ☐ NO ☐ UNKNOWN

   If yes, please provide the following information:

Reason for high claim	Begin date	End date	Estimated cost

3. Are you aware of any of the following health conditions of any member of your health plan, now or in the past 12 months?
   a. Awaiting or has received an organ and/or tissue transplant: ☐ YES ☐ NO
   b. Newborn with major health problems, respirator dependent and/or extremely low birth weight: ☐ YES ☐ NO
   c. Cancer in the last two years: ☐ YES ☐ NO
   d. Other serious health problems: ☐ YES ☐ NO
   e. If yes to any of the above, please provide known details: _____

4. How many employees and/or dependents are on COBRA: _____
   a. Do they have known health problems? ☐ YES ☐ NO ☐ UNKNOWN

5. Current carrier information:
   a. Current Medical carrier: _____ # Years with carrier _____
      Please attached most recent renewal letter and any attachments.

Employer certification:

As a representative of the named employer, I certify that the information provided is complete and accurate to the best of my knowledge available to the employer. The employer has completed appropriate due diligence in obtaining the requested information and I am in a position to certify this on behalf of the employer.

I further understand that the information provided here will be relied upon by Blue Cross and Blue Shield of Minnesota and if such information is materially incomplete or incorrect, the coverage will be subject to the rate adjustment, with 30 days' notice.

Name: (printed): _____

Title: _____ Date: _____

The purpose of this questionnaire is to obtain information on potential claims and utilization. This information along with requested documentation will be used to determine the appropriate rate level. Your assistance is appreciated.

The following is for informational purposes only

Underwriting Requirements

Blue Cross and Blue Shield of Minnesota Medical

1. Employer address and nature of business.
2. Two years of documented claims utilization from the current carrier. Claims must be broken out by plan if there are multiple plans in place. Utilization must be current and consecutive.
3. Rates that coincide with the claims utilization. This should also include the proposed rates from the incumbent carrier.
4. Benefit outline that coincides with the claims utilization.
5. The number of singles/families and/or members covered by month during the claims utilization period.
6. Employee census. For Medical, this information must include: employee identifier, date of birth, sex, employee home ZIP code, medical plan option elected if multiple plan offerings and single/family coverage type.
7. Employer contribution towards single and family premiums.

Additional Information

Retirees and 1099 Contractors are excluded.
Housing First Minnesota membership is required.