Employer Risk Assessment Form

1. About Your Group:

Group Name:			Federal Tax ID:	
Address:	City:	County:	State:	Zip Code:
SIC Code:	Nature Of Business:	Years In Business:	Phone Number:	

Has this group ever been known by another name? ☐ No ☐ Yes If yes, what name(s)?

Has this group ever requested a proposal from Paramount before? ☐ No ☐ Yes If yes, when?

Is this group affiliated with other companies or unions (parent, subsidiary, joint venture, etc.)? ☐ No ☐ Yes If yes, describe.

2. Employer Premium Contribution Level: Per Employee: _____ Dependents: _____

3. Medical Plans Offered During The Last 5 Years:

Carrier Name:	Type of Plan:	Funding:	Effective Date:	Cancel Date:	Reason For Leaving:

4. Rate History:

	Prior Year Rates	Current Rates	Renewal Rates
Single:			
Employee + Spouse:			
Employee + Child(ren):			
Family:			

5. Enrollment:

	Active	COBRA	Retired
Current Active Employees (FT+PT):	A.)		
Ineligible Employees (PT+1099):	B.)		
Total Eligible (A.-B.):	C.)		
Waivers (Life Only & Total Waivers):	D.)		
COBRA Enrolled & Retirees:		Ei.)	Eii.)
Total Applying (C.-D.+Ei.+Eii.):	F.)		

6. Cobra: Are there currently any members who are Cobra eligible or enrolled? ☐ No ☐ Yes (please list)

Name:	SSN:	Date of Qualifying Event:	Expiration Date:	Qualifying Event:

7. Retirees: Are there currently any retirees who meet the eligibility requirements? ☐ No ☐ Yes (please list)

Name:	SSN:	Age at Retirement:	Date of Retirement:	Date of Hire:

8. Medical Expenses: Are there any participating members who have incurred medical expenses in excess of $10,000 in the last 18 months? ☐ No ☐ Yes (please list)

Name:	Employee, Spouse, Dependent:	Diagnosis:	Claim Amount:	Status:

9. Medical Information:

A. Are any employees or dependents currently scheduled for surgery or hospitalization? ☐ No ☐ Yes

If yes, please describe: _____

B. Have any employees or dependents been hospitalized in the last 24 months? ☐ No ☐ Yes

If yes, please describe: _____

C. Are any employees currently on disability? ☐ No ☐ Yes

If yes, please describe: _____

D. Please indicate the number of employees or dependents who have been, currently are, or anticipate being treated for the following conditions. Please provide date.

E. In completing this application and answering questions herein, you should not include any genetic information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you and/or your dependents may be at risk.

	AIDS, ARC, HIV+		Hemophilia
	Alcohol or Dug Abuse (within 5 years)		Kidney Dialysis/Renal Failure
	Alzheimer's		Liver (Cirrhosis)
	Aneurysm *Type:*		Liver (Hepatitis, Non-Alcoholic)
	Arthritis (Rheumatoid)		Lupus
	Attempted Suicide (within 5 years)		Lyme's Parasitic Disease
	Back/Spine Injuries *Type:*		Lymphoma/Leukemia
	Cancer Treated <12 Months *Type:*		Mental or Emotional Disorders *Type:*
	Cancer Treated 1-2 Years *Type:*		Multiple Sclerosis
	Cancer Treated 3-5 Years *Type:*		Muscular Dystrophy
	Cancer Treated 6-10 Years *Type:*		Myasthenia Gravis
	Cancer Treated >10 Years *Type:*		Paralysis
	Cerebral Palsy		Pericarditis
	Coronary Artery Disease (within 5 years)		Pregnancy *Due Date:*
	Coronary Bypass		Spina Bifida
	Crohn's Disease		Stroke (within 5 years)
	Cystic Fibrosis		Transplant, Bone Marrow ☐ Pending ☐ Received
	Diabetes ((Dietary Contolled)		Transplant, Heart ☐ Pending ☐ Received
	Diabetes (Oral Medication)		Transplant, Kidney ☐ Pending ☐ Received
	Diabetes (Insulin)		Transplant, Liver ☐ Pending ☐ Received
	Emphysema		Transplant, Lung ☐ Pending ☐ Received
	Epilepsy		Transplant, Pancreas ☐ Pending ☐ Received
	Heart Attack		Ulcerative Colitis

E. If there is any additional information, either pertaining to conditions indicated above or others that would be helpful to us in assessing the medical risk of your group, please describe below or attach additional pages.

_____

_____

_____

10. Signature: I certify that I understand the contents of this form and that the information stated within is true and correct to the best of my knowledge and that I will promptly notify Paramount of any changes. Any deliberate omission or misstatement relating to answers or statements on this form can result in denial of a claim or the rescission of coverage for the group or any group member. I understand that this form is used by Paramount to evaluate my group as part of the proposal process and that this is not an application for insurance.

Print Name and Title	Broker
Signature	Date
Paramount Representative	Date