PEO4ME Simplified Underwriting Risk Review Form

Any person who intends to defraud or knowingly facilitates fraud against an insurer, submits applications or files a claim containing a false or deceptive statement, is guilty of insurance fraud.

Full Legal Name of Employer			
Employer Plan Sponsor-Responsible Party		Job Title	
Address (Employer Headquarters)		Phone	Website Address
City/State	ZIP Code	Email Address	
Renewal Date	Total Covered Employees on the Current Plan		
Is Current Group Medical Coverage ☐ Fully Insured ☐ Level-Funded ☐ Self-Funded			
Name of Current Group Medical Carrier			In Effect Since
Broker Name			Phone

I confirm I have reviewed all records and information available to me in answering the following questions regarding all plan participants and dependents including those on COBRA. ☐ Yes ☐ No

A. Have you received paid claims, large claimant or utilization reports in the last 6 months? If yes, please provide information received. ☐ Yes ☐ No

B. Have any employees or dependents, including those on COBRA, been hospitalized, had surgery or had more than $10,000 in medical expenses in the last 12 months? ☐ Yes ☐ No

C. Are any employees or dependents currently pregnant? ☐ Yes, how many? _____ ☐ No

D. Have any employees or dependents, including those on COBRA, been advised that hospitalization or surgery will be necessary in the next 12 months? ☐ Yes ☐ No

E. Has any employee or plan participant been absent for more than 5 consecutive workdays in the past 12 months for their own or their dependents accident or illness? ☐ Yes ☐ No If yes: Date returned to work _____/_____/_____

F. Are any employees or dependents receiving medical assistance for payment of medical/or prescription drug claims through a non profit entity or foundation other than the standard commercial healthcare provider and insurance system? ☐ Yes ☐ No

G. Within the past 4 years, has any employee or dependent, including those on COBRA, received or are scheduled to receive treatment for any of the following disorders or conditions?

a. Transplant . . . . . ☐ Yes ☐ No
b. End Stage Renal Disease . . . . . ☐ Yes ☐ No
c. Cancer. . . . . ☐ Yes ☐ No
d. Receiving injectable medications?. . . . . ☐ Yes ☐ No

If you answered "Yes" to B, C, D, E, F or G, please provide the following details: (If needed, please include an additional page)

Question	Disorder/Condition	Dates of Treatment	Medications	Prognosis/Current Treatment

I represent to the best of my knowledge the information provided is accurate. I understand the data included in this form is used in underwriting and shall be relied upon in determining rates. PEO 4 Me has the right to revise rates retrospectively or prospectively for the stop-loss insurance contract if false, incomplete or misleading information is provided in this form, or failure to notify PEO 4 ME of any changes to the answers to the medical questions above resulting in material misrepresentation affecting the assessment of the risk or terms or conditions for coverage. I also understand a change in final enrolled census could result in a change in rate.

Employer/Plan Sponsor Responsible Party (Signature) _____ Date _____

Cannot be signed more than 90 days from the requested effective date.