WEAtrust
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EMPLOYER QUESTIONNAIRE FOR PROPOSAL REQUEST

GROUP INFORMATION

1. Employer Name: _____
2. Street Address: _____
3. City: _____ State: _____ ZIP Code: _____ Phone Number: _____
4. Requested Effective Date: _____
5. Current health plan carrier: _____ Renewal date: _____
6. Number of different health plan carriers in past five years: _____
7. WEA Sales Representative: _____ Agent/Agency: _____
8. Number of eligible employees: _____
9. Number of eligible employees currently enrolled: _____
10. Do you cover retirees? ☐ Yes ☐ No
    How many, under age 65? _____ How many, age 65 or older? _____
11. Percentage of employer contribution: Eligible employees: _____ Retirees: _____
12. During the last 24 months, has your group been cancelled, non-renewed, or declined a quote by any health or life carrier? ☐ Yes ☐ No If yes, please provide details _____

MEDICAL INFORMATION

Please answer the following questions to the best of your knowledge.

1. Has any employee missed work for 10 or more consecutive days in the past 12 months due to an illness or injury? ☐ Yes ☐ No
2. Are any employees, dependents, COBRA beneficiaries, or covered retirees, currently disabled, handicapped, confined at home, or confined to a hospital or treatment facility due to an illness or injury? ☐ Yes ☐ No
3. Are any employees, dependents, COBRA beneficiaries, or covered retirees, on sick leave, medical leave of absence, or unable to perform his or her job duties on a full-time basis due to an illness or injury? ☐ Yes ☐ No
4. Have any employees, dependents, COBRA beneficiaries, or covered retirees, incurred more than $25,000 in medical expenses in the last 24 months? ☐ Yes ☐ No
5. Have any employees, dependents, COBRA beneficiaries, or covered retirees, been scheduled for hospitalization or surgery in the future? ☐ Yes ☐ No
6. Has any employee, dependent, COBRA beneficiary, or covered retiree, received treatment, been advised to seek treatment, or had medication prescribed within the past 24 months for any of the following? Check all that apply:

☐ Cancer or abnormal growth
☐ Diabetes
☐ Kidney disorder
☐ Liver disorder
☐ Lung disorder
☐ Psychological disorder
☐ Heart or vascular disease, or stroke
☐ Lupus, multiple sclerosis, or muscular dystrophy
☐ Arthritis or other joint disorder
☐ Blood disorder
☐ Crohn's disease/Ulcerative colitis
☐ AIDS or AIDS-related complex
☐ Alcohol/drug abuse or dependence
☐ Transplant
☐ Immune system disorder
☐ Congenital/birth defects
☐ ALS (Lou Gehrig's disease)
☐ Serious accident (e.g., paralysis, comatose)

Continued on next page

If you answered "Yes" to any of the Medical Information questions on the prior page, or if you know of any other conditions that may exist, please provide additional information below. If additional space is needed, please attach a signed and dated separate sheet of paper. (HIV testing and genetic test results need not be revealed.)

Question #	Name	Age	Status*	Medical Diagnosis/ Condition	Dates of Treatment	Medication Name

*Status: E=Employee, D=Dependent, C=COBRA, R=Retiree

EMPLOYER CERTIFICATION

I certify that this information is complete and accurate to the best of my knowledge. I understand the WEA Insurance Corporation relies on the information contained herein to assess medical risk for coverage requested by the group; therefore, the WEA Insurance Corporation reserves the right to modify rates provided based on information disclosed on this form, if additional information is received. I further understand that if the Employer elects to apply for coverage with the WEA Insurance Corporation, this Questionnaire will be attached to the Employer Group Application as an addendum and incorporated as part of the contract therein.

Employer Signature:_____ **Title:**_____

Date:_____

AGENT CERTIFICATION

I certify that this information is complete and accurate to the best of my knowledge. I understand that I have no authority to alter this Questionnaire.

Agent Signature:_____ **Date:**_____