



Group Medical Assessment Form

The following information will be used by Hometown Health to assess the medical risk of a group.

Legal Name of Group: _____

AKA: _____

STEP 1. Please provide 3 years of recent claims experience including premiums, paid claims, incurred claims and number of employees or members. Also include any large/shock claim reports that are available.

STEP 2. Please include group's current and renewal rates.

STEP 3. Please complete Sections A-D below:

A. How many retired employees are eligible for this plan? _____

B. List by employee, dependent or continuee any individual who has had a claim over \$10,000 occurring in the past twelve (12) months.

Please Circle	Claim Amount	Illness/Diagnosis
Employee/Dependent/COBRA _____	\$ _____	_____
Employee/Dependent/COBRA _____	\$ _____	_____
Employee/Dependent/COBRA _____	\$ _____	_____
Employee/Dependent/COBRA _____	\$ _____	_____

C. Does any employee, dependent or continuee* currently have any known or ongoing health conditions such as:

Cancer; Heart Disease; Brain Disorders; Hepatitis	Yes	No
Disorders of the Immune System; Diabetes; Arthritis	Yes	No
Mental Disorders; Substance Abuse; Alcoholism	Yes	No
Liver, Lung or Kidney Diseases; Organ Transplants	Yes	No
Back, Neck or Joint Disorders; Respiratory Illnesses	Yes	No

If yes, please provide dates, diagnoses and number of individuals with the condition (attach additional sheets if needed): _____

A continuee is any non-active employee (including his/her dependents) who is covered under your current group policy as defined by the Consolidated Omnibus Budget Reconciliation Act (COBRA) July 1, 1986.

D. Please list below, by name, the following individuals who may apply in any of the following categories:

i. Individuals who have elected COBRA, and also those who have not yet elected COBRA but are eligible to do so.

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

ii. Any handicapped or other dependent who is over the age of 19 and not a full-time student.

Name: _____ Name: _____

Name: _____ Name: _____

Name: _____ Name: _____

iii. Individuals who have elected COBRA and are currently disabled.

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____

iv. Any individual with unusual circumstances not listed above.

Name: _____ Condition: _____

Name: _____ Condition: _____

Name: _____ Condition: _____

I understand that Hometown Health reserves the right to request any additional Claims information.

The information included on this form is complete and accurate to the best of my knowledge And belief.

Signed: _____ Date: _____

Printed Name: _____ Title: _____