



WASHINGTON ALLIANCE FOR HEALTHCARE INSURANCE TRUST

GROUP HEALTH RISK QUESTIONNAIRE

(Expires 90 days after date completed)

Group Name:	Date Completed: / /
-------------	-----------------------------

- **BROKERS/AGENTS** Please ask these questions of a person of authority at the group who has general knowledge of the group insurance plan such as an owner, a corporate officer, a human resources manager, or other manager or supervisor.
- **WITHOUT PROVIDING NAMES**, please answer the following questions *to the best of your knowledge* for the subscribers and their dependents to be covered under your group medical plan, including COBRA participants.
- **ALL QUESTIONS MUST BE ANSWERED "YES" OR "NO"** If unknown, check the "No" box. Clarification must be provided when answering "Yes" to any questions.

<input type="checkbox"/> Yes <input type="checkbox"/> No	(1) Are any participants or covered dependents pregnant? <i>If so, how many? Due dates?</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	(2) Has any participant or covered dependent been treated for or is expected to be treated for a serious illness or injury (e.g., cancer, AIDS, substance abuse, juvenile diabetes, cardiovascular diseases, mental illness, multiple sclerosis, rheumatoid arthritis, renal disease, pulmonary disease, etc.), been hospitalized or had surgery in the past 12 months, or is expected to be hospitalized or is expecting to undergo surgery in the next 12 months? <i>If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	(3) Has any participant or covered dependent had in the past 12 months or expect to have in the next 12 months a health claim of \$5,000 or more? If you are unsure as to the cost of the individual's potential medical expenses, please list the condition to the best of your knowledge. <i>If so, please clarify with dates, diagnosis, prognosis, follow-up care, on-going treatments, etc.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	(4) Are any participants or covered dependents currently absent from work or about to be absent from work by reason of illness or injury, confined at home or in the process of being confined at home by their physician, in a hospital or about to be admitted to a hospital or other treatment facility such as a nursing home or convalescent center, at home receiving or about to be receiving home care from a licensed home health care agent, at home or about to be at home receiving hospice care, or otherwise physically or mentally incapacitated or about to be incapacitated? <i>If so, please describe the circumstances, diagnosis, prognosis, expected recovery, on-going treatments, etc.</i>

Name of Agent/Broker

Name of Authorized Group Representative

Signature of Agent/Broker

Signature of Authorized Group Representative