

Propel HR

PROSPECTIVE CLIENT HEALTH QUESTIONNAIRE

PROSPECTIVE CLIENT INFORMATION				
Contact			Phone #	
			Fax #	
			E-mail:	
Full Legal Name of Prospective Client				
Address	City	County	State	Zip
Nature of Business				

Employer Structure:				
Proprietorship	Partnership	C-Corporation	S-Corporation	
Limited Liability Company		Other / Explain:		
Federal Tax I.D.#:		Year Business Started:		

CURRENT COVERAGE INFORMATION	
Do you currently have a group health insurance plan?	Yes No
Current or recent group insurance carrier: Medical:	_____ Dental: _____
Deductible: _____	Co Insurance (80/60, 90/70): _____
Number of Employees: _____	Number of Eligible Employees: _____

Prospective Client's Cost of Health Insurance per EE per Month			
EE Only	EE+ Spouse	EE+ Child(ren)	Family
\$ _____	\$ _____	\$ _____	\$ _____

Health Insurance rates will be obtained using the information provided on the attached health questionnaires. Underwriting reserves the right to adjust rates or decline coverage based upon information obtained from the employee enrollment applications.

I have read and understand the above information.

Client Signature

Date

Propel HR

Date

CLIENT MEDICAL QUESTIONS

All Questions Must Be Answered.

1. Has any Employee or their Dependents received treatment for any serious or chronic illness or injury within the last 24 months? YES NO
2. Has any Employee or their Dependents been treated in the last 24 months for: Cancer, Diabetes, High Blood Pressure, Acquired Immune Deficiency Syndrome (AIDS), or any other total or partial disability which lasted (or can reasonably be expected to last) more than 3 months? YES NO
3. Has any Employee or their Dependents been treated for any Muscular-Skeletal condition such as: Arthritis, Bursitis, Gout, Back/Spine, Bone, Joint or Tendon Pain, Injury or Disorder, Physical Handicaps, Polo, etc? YES NO
4. Has any Employee or their Dependents been treated for any Skin Disorder such as: Cancer, Melanoma, Psoriasis, Keratosis, Herpes, Birthmarks, Warts, etc? YES NO
5. Has any Employee or their Dependents been treated for any Birth Defects? YES NO
6. Has any Employee or their Dependents taken Prescription Medication in the last 12 months?
YES NO If yes, please provide name of medication, dosage and how long person has been on medication on the attached Employee Medical History form.
7. Is any Employee currently on COBRA benefits? YES NO
8. Is any Employee or their Dependents Pregnant? YES NO
9. Has any Employee or their Dependents been treated for High Blood Pressure or Diabetes? Yes No If yes, please provide dates and readings for the last three blood pressure or blood sugar readings.

If you answered "YES" to any of the questions please explain in FULL DETAIL on the attached Employee Medical History form. If you do not know the answers to the above questions please have your Employees fill out the Employee Medical Questions

EMPLOYEE MEDICAL HISTORY

(To be completed by Prospective Client)

Name: Last	First	Middle	Status: Employee Spouse Child
Date of Birth	Sex	Zip Code	Coverage Selected
Illness / Impairment:			
Medication / Treatment:			
Physician Name			
Address:			Phone:
Name: Last	First	Middle	Status: Employee Spouse Child
Date of Birth	Sex	Zip Code	Coverage Selected
Illness / Impairment:			
Medication / Treatment:			
Physician Name			
Address:			Phone:
Name: Last	First	Middle	Status: Employee Spouse Child
Date of Birth	Sex	Zip Code	Coverage Selected
Illness / Impairment:			
Medication / Treatment:			
Physician Name			
Address:			Phone:
Name: Last	First	Middle	Status: Employee Spouse Child
Date of Birth	Sex	Zip Code	Coverage Selected
Illness / Impairment:			
Medication / Treatment:			
Physician Name			
Address:			Phone:

EMPLOYEE MEDICAL QUESTIONS

All Questions Must Be Answered.

1. Have you or your Dependents received treatment for any serious or chronic illness or injury within the last 24 months? YES NO
2. Have you or your Dependents been treated in the last 24 months for: Cancer, Diabetes, High Blood Pressure, Acquired Immune Deficiency Syndrome (AIDS), or any other total or partial disability which lasted (or can reasonably be expected to last) more than 3 months? YES NO
3. Have you or your Dependents been treated for any Muscular-Skeletal condition such as: Arthritis, Bursitis, Gout, Back/Spine, Bone, Joint or Tendon Pain, Injury or Disorder, Physical Handicaps, Polio, etc?
YES NO
4. Have you or your Dependents been treated for any Skin Disorder such as: Cancer, Melanoma, Psoriasis, Keratosis, Herpes, Birthmarks, Warts, etc? YES NO
5. Have you or your Dependents been treated for any Birth Defects? YES NO
6. Have you or your Dependents taken Prescription Medication in the last 12 months?
YES NO If yes, please provide name of medication, dosage and how long person has been on medication on the attached Employee Medical History form.
7. Are you or your Dependents Pregnant? YES NO
8. Has any Employee or their Dependents been treated for High Blood Pressure or Diabetes? Yes No If yes, please provide dates and readings for the last three blood pressure or blood sugar readings.

If you answered "YES" to any of the questions please explain in FULL DETAIL on the attached Employee Medical History.

EMPLOYEE MEDICAL HISTORY

(To be completed by Employee)

Name: Last	First	Middle	Status: Employee Spouse Child	
Date of Birth	Sex	Zip Code	Coverage Selected	
Illness / Impairment:				
Medication / Treatment:				
Physician Name				
Address:			Phone:	
Name: Last	First	Middle	Status: Employee Spouse Child	
Date of Birth	Sex	Zip Code	Coverage Selected	
Illness / Impairment:				
Medication / Treatment:				
Physician Name				
Address:			Phone:	
Name: Last	First	Middle	Status: Employee Spouse Child	
Date of Birth	Sex	Zip Code	Coverage Selected	
Illness / Impairment:				
Medication / Treatment:				
Physician Name				
Address:			Phone:	
Name: Last	First	Middle	Status: Employee Spouse Child	
Date of Birth	Sex	Zip Code	Coverage Selected	
Illness / Impairment:				
Medication / Treatment:				
Physician Name				
Address:			Phone:	