



## PEO Information Request (page 1 of 4)

This questionnaire must be filled out completely. Please be sure to indicate "None" if applicable. Clear Employer Services will not accept the questionnaire if incomplete.

Date \_\_\_\_\_

Proposed Effective Date: \_\_\_\_\_

<b>I. COMPANY AND CURRENT ENROLLMENT INFORMATION</b>					
<b>Company Name</b>					
<b>Street Address</b>					
<b>City</b>		<b>State</b>		<b>Zip</b>	
<b>County</b>		<b>Benefits Contact &amp; Phone #</b>			
<b>Total Number of employees on payroll:</b>	<b>Total Full Time:</b>		<b>Total Number of employees currently enrolled in health care plan:</b>		
		<b>Total Part Time:</b>			
<b>Current Health Carrier:</b>			<b>Health Carrier Renewal Date:</b> ____ / ____ / ____		
<b>Years with Current Carrier:</b>			<b>Renewal Rates Received?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Is Claims Experience available for your group?</b> <input type="checkbox"/> Yes (provide reports) <input type="checkbox"/> No					
<b>Is your current Plan Self-Funded?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know ***If yes, please provide claims.					
<b>Are you currently with a PEO?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Does your Company currently have a Wellness Program in place?</b> <input type="checkbox"/> Yes (attach details) <input type="checkbox"/> No		
<b>If yes, name of PEO:</b>					
<b>Please provide a description of your business operation:</b>			<b>Does your Company currently have a Smoking or Tobacco Cessation program in place?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Number of Locations:</b> _____		<b>Please identify all states of operation:</b> _____			
<b>Are any health plan enrollees NOT paid employees (other than spouses or children)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No					

**A. List any current COBRA / State Continuation participants:  NONE**

Name / DOB / Phone # of Individual	COBRA / Continuation Effective Date	Activating Event / Date (i.e. employee termination, etc.)

**B. List any participants currently eligible for COBRA who have not yet elected coverage and/or any participants who will become eligible for COBRA prior to the Health Plan effective date:  NONE**

Name / DOB / Phone # of Individual	Date Eligible	Activating Event/Date

## PEO Information Request (page 2 of 4)

<b>II. CURRENT HEALTH PLAN EMPLOYER CONTRIBUTION INFORMATION</b> <i>(Does your company have more than one Contribution Level? If so, please list each separately)</i>				
	Employee Only	Employee + Spouse	Employee + Child	Family
<b>Company Contribution Levels (\$ or %)</b>				
<b>Company Contribution Levels (\$ or %)</b>				

<b>III. RATE HISTORY &amp; PLAN DESIGN DETAILS</b> (include the 3 most elected plans)				
<b>Plan 1 Name:</b> _____	# Enrolled _____	Renewal Rates (eff. __/__/__)	Current Rates (eff. __/__/__)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
Enrollment		Premium Rates or Total Premiums	Plan Design Details	
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out of-Pocket Max\$ _____ <small>(excluding ded.)</small>
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs __/__/__

<b>Plan 2 Name:</b> _____	# Enrolled _____	Renewal Rates (eff. __/__/__)	Current Rates (eff. __/__/__)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
Enrollment		Premium Rates or Total Premiums	Plan Design Details	
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out of-Pocket Max\$ _____ <small>(excluding ded.)</small>
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs __/__/__

<b>Plan 3 Name:</b> _____	# Enrolled _____	Renewal Rates (eff. __/__/__)	Current Rates (eff. __/__/__)	<input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> HDHP <input type="checkbox"/> POS <input type="checkbox"/> _____
Enrollment		Premium Rates or Total Premiums	Plan Design Details	
Employee Only	#	\$	\$	Annual Deductible \$ _____
Employee + Spouse	#	\$	\$	Co-Insurance % _____
Employee + Child(ren)	#	\$	\$	Out of-Pocket Max\$ _____ <small>(excluding ded.)</small>
Employee + Family	#	\$	\$	PCP Copay \$ _____ Prescription Drugs __/__/__

- **Attach a copy of your benefit & billing summary for each plan and year listed above.**
- **Include carrier claims report if available.**

## PEO Information Request (page 3 of 4)

**Next, please answer the following questions on behalf of your company to the best of your knowledge. This information will help determine if your group is best served by the implementation of a wellness program, as part of the Affordable Care Act.**

IV. WELLNESS PROGRAM IMPACT APPRAISAL	
<b>A.</b> Has anyone been treated for a serious illness, been hospitalized or had surgery in the past 5 years?	To the Best of My Knowledge  <input type="checkbox"/> YES <input type="checkbox"/> NO
<b>B.</b> Is anyone currently hospitalized, confined at home, incapacitated, confined in a treatment facility, incapable of self-support because of physical or mental disability?	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>C.</b> Has anyone been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?	<input type="checkbox"/> YES <input type="checkbox"/> NO

*(If yes to any, please provide details in the table below.)*

**D.** If anyone is currently being treated or been advised to seek treatment for any of the following, **please check all that apply:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> AIDS or testing HIV Positive | <input type="checkbox"/> kidney disorder         | <input type="checkbox"/> stroke                   |
| <input type="checkbox"/> arthritis                    | <input type="checkbox"/> liver disease           | <input type="checkbox"/> substance dependency     |
| <input type="checkbox"/> back disorder                | <input type="checkbox"/> mental illness          | <input type="checkbox"/> transplants              |
| <input type="checkbox"/> cancer                       | <input type="checkbox"/> muscular disorder       | <input type="checkbox"/> tumor                    |
| <input type="checkbox"/> diabetes                     | <input type="checkbox"/> nervous system disorder | <input type="checkbox"/> other serious conditions |
| <input type="checkbox"/> heart disease                | <input type="checkbox"/> respiratory disease     |   |

***(For all checked boxes, please provide details below)***

Name (optional)	M/F	Date of Birth	Condition	Date of Onset	Last Date Treated	Treatment/Drug	Degree of Recovery

**C. List any employees and/or dependents who are on the health plan that are disabled:**

**NONE**

Name	Disability	Qualifying Event
_____	_____	_____
_____	_____	_____
_____	_____	_____

## PEO Information Request (page 4 of 4)

<b>Is Anyone Currently Pregnant?</b> If yes, please provide due date and note below if <b>normal, high risk, multiple birth</b> , or <b>preterm labor</b> with this pregnancy.  <i>This includes employees, dependents or COBRA participants.</i>		To the Best of My Knowledge:  <input type="checkbox"/> YES <input type="checkbox"/> NO
Name (optional)	Due Date	Type of Pregnancy or Condition (normal, high risk, preterm labor, etc.)

I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind enrollment or coverage. I will notify Clear Employer Services of any changes that occur after signing this questionnaire.

In the event that material information has been omitted or is inaccurate, Clear Employer Services service agreement may terminate for breach of contract resulting from the material misrepresentation.

Clear Employer Services gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment.

Clear Employer Services Program Notice of Privacy Practices provides more detailed information about how Clear Employer Services Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. Clear Employer Services Program and my health plan are not required by law to grant my request. However, if my request is granted, Clear Employer Services Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent Clear Employer Services Program or my health plan have already used or disclosed my protected health information in reliance upon my consent.

*Information disclosed on this form is considered valid for effective dates within 90 days of date signed. I will notify Clear Employer Services of any changes that occur after signing this questionnaire and prior to starting health coverage. I understand that Clear Employer Services reserves the right to re-review based on a change in the Census or other information.*

<b>Authorized Signature</b>	<b>Title</b>	<b>Date</b>
<b>Print Name</b>	<b>Print Name of Company</b>	
<b>Broker / Sales Signature</b>	<b>Broker / Sales Print Name</b>	<b>Date</b>