



Business Health Trust
Health Risk Questionnaire

Program Management Provided by
Wells Fargo Insurance Services

This form will not be accepted without all questions being answered. If an answer is zero ("0"), than include that in the field. If the group or the agent has no knowledge of the information being requested, include "Not available" in the comment field of each such question. This form must be signed by both the agent and the group representative. If the questionnaire is completed over the phone, we will accept the name and title of the group representative and that it was a phone interview in lieu of the signature.

Group Name: _____

HEALTH/WELLNESS PROMOTION

1. Do you offer injury prevention classes such as back care, repetitive motion disorders, proper lifting and use of heavy equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have a drug/alcohol screening program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Please check any of the following your company provides:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> cholesterol screenings <input type="checkbox"/> on-site flu shots		
<input type="checkbox"/> blood glucose screenings <input type="checkbox"/> blood pressure checks		

ADVERSE RISK FACTORS

4. How many employees are currently on medical leave of absence or are absent from work for medical reasons for more than 3 consecutive workdays?	_____	
5. How many participants or covered dependents are pregnant?	_____	
6. 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, cardiovascular diseases, renal disease, pulmonary disease, etc.)? If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc. _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Has any participant or covered dependent been treated for or is expected to be treated for an ongoing illness (e.g., juvenile diabetes, substance abuse, mental illness, multiple sclerosis, rheumatoid arthritis, etc.)? If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc. _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. How many persons are presently covered under the Continuation of Medical Benefits as defined under COBRA who will probably continue coverage under this plan?	_____	
9. 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 \$10,000 or more? If you are unsure as to the cost of the individual's potential medical expenses, please list the conditions to the best of your knowledge. If so, please clarify with dates, diagnosis, prognosis, follow-up care, on-going treatments, etc. _____ _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I have provided these answers as part of the application procedure required by Business Health Trust and I certify that all information completed on this form is true, correct, and complete. I understand that Business Health Trust will rely on each answer in making coverage and rating determinations. If Business Health Trust issues a Contract with the Group and then finds untrue, incorrect, or incomplete information has been provided, and if as a result of correcting false information the Group no longer qualifies for the Rate quoted, I understand that Business Health Trust will have the right to adjust the rates.

Broker Signature/Date:

Group Signature/Date: