GROUP HEALTH QUESTIONNAIRE

1. Were there any employees or dependents who incurred medical expenses of $10,000 or more during the last 12 month period? Yes No
2. Are there any physically handicapped dependents over age 19 covered by the current carrier? Yes No
3. Are there any COBRA enrollees? Yes No If yes, how many?____________________
4. Are there any employees or dependents to be covered under the proposed coverage who currently have serious health problems? (for example, but not limited to: cancer, heart trouble, neuromuscular disorder, AIDS, hepatitis, liver disorder, kidney trouble, paralysis, lung disease, blood disorder or diabetes) Yes No
5. In the last 12 month period, has any employee been facility confined or received treatment on a recurring basis for Mental and Nervous and/or Substance Abuse? Yes No
6. Are there any maternity cases? Yes No If yes, how many?____________________
7. Is there anyone on disability or on waiver of premium status? Yes No
8. If the answer to any of the above is yes, please give details including:

Health Conditions (Dates):____________________

Type of Treatment and Charges or Potential Charges:____________________

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Type of Treatment and Charges or Potential Charges:____________________

(Attach additional pages if necessary)

I understand and agree that this information is considered as part of the basis for issuing a group policy and establishment of premium rates. If a proposal of benefits and rates has already been issued, answers to, or changes in the answers to, the above questions will be cause for re-rating or cancellation of the group or withdrawal of any proposal.

____________________ Signature of Applicant (Employer)

____________________ Signature of Agent/Representative

____________________ Title of Applicant

____________________ Date