



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYER GROUP QUESTIONNAIRE

Group's Legal Name _____ EID# _____

Group Name to appear on ID Card _____ SIC# _____

Address _____

City _____ State _____ Zip _____

Contact Person _____ Telephone _____ Fax _____

Contact Email _____ # of Years in Business _____

Billing Address (If Different) _____

Organization Type

☐ Partnership ☐ C-Corp ☐ S-Corp ☐ LLC/LLP ☐ Ind. Contractor ☐ Non-Profit ☐ Sole Proprietor ☐ Other _____

Employer Contribution: _____ % Or \$ _____ per employee

Waiting period for new hires: ☐ None ☐ One month after hire date ☐ Two months after hire date ☐ Three months after hire date

Have Worker's Comp? ☐ Yes ☐ No Worker's Comp Carrier Name _____

Names of Owners/Partners not covered by Worker's Comp _____

Eligible Employees working in FL _____ # Eligible Employees working outside FL _____

Ineligible Employees _____ # Excluded Employees _____

(Have not satisfied waiting period or work less than 25 hours per week)

(Have other group or public coverage)

Total Employees _____ # Persons currently on COBRA/Continuation _____

Names of Persons currently on COBRA/Continuation: _____

Does the group currently have health coverage? ☐ Yes ☐ No If yes, Name of Carrier is _____

Has the group had coverage in previous 12 months? ☐ Yes ☐ No If yes, Name of Carrier was _____

Do you offer benefits to your employees through a professional employer organization or similar mechanism? ☐ Yes ☐ No

Signature Section

I understand that Florida Health Choices and participating vendors will rely on the information I provide in determining eligibility for coverage, setting premium rates, compliance with applicable laws, and other purposes, and that any material misrepresentation or fraudulent statement may result in rescission of the group policy, termination of coverage, increase in premiums, or other consequences. Florida Health Choices and its participating vendors reserve the right to audit and to request documentation as evidence of business activity at any time and from time to time in order to validate my compliance with eligibility and underwriting guidelines as well as validate the applicability of State and Federal laws. I understand that my failure to comply with any such request may also result in termination of coverage, increase in premiums, or other consequences.

Employer Business Name _____ Date _____

Authorized Signature _____ Print Authorized Name _____

Agent Name _____ Agent Marketplace I.D. _____ Agent Signature _____

ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE OR SHE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYER MEDICAL QUESTIONNAIRE

Group's Legal Name _____

Contact Person _____ Contact Email _____

Contact Telephone _____ Contact Fax _____

GROUP MEDICAL PROFILE FOR GROUPS SIZE 10-50

Answer the following questions to the best of your knowledge for all eligible employees and dependents.
Your answers to these questions must include all COBRA individuals covered by your present plan.

☐ Yes ☐ No

1. Have any employees or dependents been diagnosed or treated by a licensed medical provider during the past five years for:

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Back Disorder | <input type="checkbox"/> Hemophilia/Blood Disorders |
| <input type="checkbox"/> Tumor | <input type="checkbox"/> Brain/Nervous/Seizures | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Heart/Circulatory | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Connective Tissue Disorder | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Immune Disorder | <input type="checkbox"/> Lupus | <input type="checkbox"/> Immuno Deficiency |
| <input type="checkbox"/> Reproductive Disorder | <input type="checkbox"/> Chronic Lung Disorder | <input type="checkbox"/> Growth Hormones | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Intestinal Disorder | <input type="checkbox"/> Kidney Disease/Failure | <input type="checkbox"/> Transplants | <input type="checkbox"/> Other Conditions |
| <input type="checkbox"/> Endocrine Disorder | <input type="checkbox"/> Liver Disorders (Hepatitis) | | |

☐ Yes ☐ No

2. Are any employees or dependents currently pregnant?
If yes, how many and what are the expected delivery dates? _____

☐ Yes ☐ No

3. Have any employees or dependents been hospitalized (inpatient or outpatient) or had any surgical operations during the past 12 months?

☐ Yes ☐ No

4. Have any employees been absent from work, confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 12 months?

☐ Yes ☐ No

5. Are any employees or dependents receiving disability benefits of any type including Social Security Income, Worker's Compensation and Medicare?

☐ Yes ☐ No

6. Has anyone had claims more than \$7500 in the last 12 months?

Please provide details to all "YES" responses in the spaces provided below. Additional sheets may be used if needed.

Question#	Date(s)	Diagnosis	Amount of Claim	Current Health Status



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYEE AND FAMILY MEDICAL QUESTIONNAIRE

SECTION 1: EMPLOYEE INFORMATION

Employer Name _____

Name of Family Members Applying for Coverage	Relationship	Social Security Number	Date of Birth	Gender Male/Female	Height (feet, inches)	Weight (pounds)
	Employee					
	Spouse					
	Dependent					
	Dependent					
	Dependent					
	Dependent					
	Dependent					

SECTION 2: EMPLOYEE INFORMATION

Within the past two (2) years has a licensed member of the medical profession diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment from a licensed member of the medical profession? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply. **For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.**

A. Heart/Circulatory ☐ YES ☐ NO

- ☐ A1. Anemia
☐ A2. Angina
☐ A3. Angioplasty/Stent
☐ A4. Aneurysm
☐ A5. Blood Clots
☐ A6. Blood Disorder
☐ A7. Bypass
☐ A8. Cardiac Arrhythmia
☐ A9. Chest Pain
☐ A10. Congestive Heart Defect
Type _____
Operated _____
☐ A11. Congestive Heart Failure
☐ A12. Coronary Heart Disease
☐ A13. Heart Murmur
☐ A14. Hemophilia
☐ A15. High/Low Blood Pressure
☐ A16. High Cholesterol
☐ A17. Pacemaker (Reason Implanted: _____)
☐ A18. Palpitations
☐ A19. Sickle Cell Anemia
☐ A20. Stroke/TIA

- ☐ A21. Varicose Veins
☐ A22. Ventricular Tachycardia
☐ A23. Other _____

B. Eyes/Ears/Nose/Throat ☐ YES ☐ NO

- ☐ B1. Acoustic Neuroma
☐ B2. Cataracts
☐ B3. Chronic Sinusitis
☐ B4. Cleft Lip/Palate
☐ B5. Detached Retina
☐ B6. Deviated Septum
☐ B7. Ear Infections
☐ B8. Glaucoma
☐ B9. Retinopathy
☐ B10. Other _____

C. Immune ☐ YES ☐ NO

- ☐ C1. ALS
☐ C2. Lupus
☐ C3. Psoriasis
☐ C4. Scleroderma
☐ C5. Other _____

D. Cancer/Tumors ☐ YES ☐ NO

- ☐ D1. Brain
☐ D2. Breast
☐ D3. Colon
☐ D4. Cyst
☐ D5. Hodgkin's Disease
☐ D6. Leukemia
☐ D7. Liver
☐ D8. Lung
☐ D9. Lymphoma
☐ D10. Melanoma
☐ D11. Ovarian
☐ D12. Pituitary
☐ D13. Prostate
☐ D14. Skin Type _____
Occurrences _____
Dates _____
☐ D15. Stomach
☐ D16. Testicular
☐ D17. Thyroid
☐ D18. Stage of Cancer if known _____
☐ D19. Cancer Treatment:
☐ Surgery ☐ Chemo ☐ Radiation
☐ D20. Other _____



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYEE AND FAMILY MEDICAL QUESTIONNAIRE

SECTION 2: EMPLOYEE INFORMATION (CONTINUED)

E. Neurological ☐ YES ☐ NO

- ☐ E1. Alzheimer's Disease
☐ E2. Asperger's Syndrome
☐ E3. Cerebral Palsy
☐ E4. Epilepsy
☐ E5. Head Injury
☐ E6. Migraines
☐ E7. Multiple Sclerosis
☐ E8. Neuritis
☐ E9. Paralysis/Hemiplegia
☐ E10. Parkinson's Disease
☐ E11. Seizures/Convulsions
 Date Diagnosed? _____
 Date last seizure? _____
☐ E11. Other _____

F. Transplants ☐ YES ☐ NO

- ☐ F1. Pending
☐ F2. On Waiting List
☐ F3. Completed Transplant
☐ F4. Bone Marrow
☐ F5. Stem Cell
☐ F6. Organ (Type: _____)
☐ F7. Other _____

G. Arthritis ☐ YES ☐ NO

- ☐ G1. Arthritis
☐ G2. Osteoarthritis
☐ G3. Rheumatoid Arthritis
☐ G4. Other _____

**H. Bones/Muscles/
Joint Disorders** ☐ YES ☐ NO

- ☐ H1. Bulging/Herniated Disk
☐ H2. Carpal Tunnel Syndrome
☐ H3. Fibromyalgia/CFS
☐ H4. Fractures (Open or Closed)
☐ H5. Gout
☐ H6. Joint Replacement (Type: _____)
☐ H7. Knee
☐ H8. Muscular Dystrophy
☐ H9. Neck/Back
☐ H10. Shoulder
☐ H11. Spina Bifida
☐ H12. Sprain/Strain
☐ H13. Other _____

I Psychological ☐ YES ☐ NO

- ☐ I1. ADD/ADHD
☐ I2. Alcoholism
☐ I3. Anxiety
☐ I4. Autism
☐ I5. Bipolar
☐ I6. Depression
☐ I7. Drug Abuse
☐ I8. Eating Disorder
☐ I9. Mental/Nervous disorder
☐ I10. Schizophrenia
☐ I11. Suicide Attempt
☐ I12. Other _____

J. Diabetes/Endocrine ☐ YES ☐ NO

- ☐ J1. Diabetes controlled by:
 ☐ a. Diet
 ☐ b. Oral Medication
 ☐ c. Insulin
 Date Diagnosed (_____) _____
☐ J2. Adrenal Glands
☐ J3. Growth Hormones
☐ J4. Other _____

K. Reproductive ☐ YES ☐ NO

- ☐ K1. Breast Disorder
☐ K2. Complications of Pregnancy
☐ K3. Endometriosis
☐ K4. Fibroids
☐ K5. Menstrual Disorder
☐ K6. Ovarian Cysts
☐ K7. Pelvic Inflammatory Disease
☐ K8. Sexually transmitted Disease
☐ K9. Other _____

L. Lung/Respiratory ☐ YES ☐ NO

- ☐ L1. Allergies
 Injections ☐ YES ☐ NO
 How Often? _____
☐ L2. Asthma
☐ L3. COPD (On Oxygen? _____)
☐ L4. Cystic Fibrosis
☐ L5. Emphysema
☐ L6. Lung Disorder
☐ L7. Pneumonia

- ☐ L8. Sarcoidosis
☐ L9. Sleep Apnea
☐ L10. Tuberculosis
☐ L11. Valley Fever
☐ L12. Other _____

M. Intestinal ☐ YES ☐ NO

- ☐ M1. Acid Reflux/GERD
☐ M2. Colitis/IBS
☐ M3. Colon Disorder
☐ M4. Colon Polyps
☐ M5. Crohn's Disease
☐ M6. Diverticulitis/Diverticulum
☐ M7. Gallbladder
☐ M8. Gastric Bypass
☐ M9. Hiatal Hernia/Reflux
☐ M10. Pancreatitis
☐ M11. Ulcer
☐ M12. Ulcerative Colitis
 ☐ Colectomy ☐ Partial ☐ Total
 ☐ Ileostomy ☐ Partial ☐ Total
☐ M13. Other _____

N. Liver/Kidney/Urinary ☐ YES ☐ NO

- ☐ N1. Bladder Disorder
☐ N2. Cirrhosis
☐ N3. Gaucher's Disease
☐ N4. Hepatitis (Type: _____)
☐ N5. Jaundice
☐ N6. Kidney Disorder
☐ N7. Kidney Stones
 (How Many? _____)
☐ N8. Liver Disorder
☐ N9. Polycystic Kidney
☐ N10. Prostate
☐ N11. Prostate Disorder
☐ N12. Renal Failure
 ☐ End Stage Renal
 ☐ Exhausted Part A Medicare
 ☐ YES ☐ NO
☐ N13. Other _____



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYEE AND FAMILY MEDICAL QUESTIONNAIRE

SECTION 2: EMPLOYEE INFORMATION (CONTINUED)

In addition to the information provided above, have you or anyone applying for coverage sought medical advice or treatment from a licensed member of the medical profession for any condition not previously mentioned in this form, including a Workers Compensation injury or illness? ☐ **YES** ☐ **NO** If yes, please provide details below.

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Date of Onset	Date Treatment Ended	Medications Prescribed	Medications Prescribed	Dosage	Still Taking Medication
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N
								<input type="checkbox"/> Y <input type="checkbox"/> N

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this enrollment form.



FLORIDA'S INSURANCE MARKETPLACE
EMPLOYEE AND FAMILY MEDICAL QUESTIONNAIRE

SECTION 3: QUESTIONS

Please answer the following questions for yourself and for anyone in your family applying for coverage:

1. ☐ **YES** ☐ **NO** Is anyone currently pregnant or an expectant parent? Due date: _____

- a. Has the pregnancy been confirmed by a physician or practitioner? ☐ Yes ☐ No
b. Pregnancy complications? ☐ Yes ☐ No
c. Multiple births expected? ☐ Yes ☐ No
d. Planned C-Section? ☐ Yes ☐ No

2. ☐ **YES** ☐ **NO** Is anyone currently, or in the past five years has anyone been, a patient in a:

- ☐ hospital ☐ clinic ☐ surgi-center ☐ urgent care facility, or ☐ other medical facility as an inpatient or outpatient?

3. ☐ **YES** ☐ **NO** Does anyone currently use tobacco products? If Yes, check applicable boxes:

- | Employee | Spouse |
|---|---|
| <input type="checkbox"/> cigarettes <input type="checkbox"/> pipes <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco | <input type="checkbox"/> cigarettes <input type="checkbox"/> pipes <input type="checkbox"/> cigars <input type="checkbox"/> chewing tobacco |

4. ☐ **YES** ☐ **NO** Is any person to be covered currently, or in the past 12 months, been advised by a licensed member of the medical profession to have any of the following?

- | | |
|--|--|
| <input type="checkbox"/> abnormal test or physical results | <input type="checkbox"/> health condition, illness or injury that may require treatment or surgery |
| <input type="checkbox"/> tests advised | <input type="checkbox"/> treatment advised |
| <input type="checkbox"/> surgery advised | <input type="checkbox"/> unexplained weight gain/loss |
| <input type="checkbox"/> unexplained fatigue | |

5. ☐ **YES** ☐ **NO** Does any person to be covered currently have any pending test results requested by a licensed member of the medical profession?

6. ☐ **YES** ☐ **NO** Has anyone applying for coverage had medical claims in excess of \$7,500 in the past 2 years?

7. ☐ **YES** ☐ **NO** Has any one applying for coverage, ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

8. ☐ **YES** ☐ **NO** In addition to the information provided above, are you taking any other prescription medications?

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PLEASE NOTE: If you leave out or misrepresent any information, it may result in cancellation of insurance, non-renewal of coverage or a change in premium for your group coverage retroactive to the date the policy became effective. You or your authorized agent are entitled to receive a copy of this form.

I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to (name of insurer). I understand the purpose of the disclosure and use of my information is to allow (name of insurer) to make decisions regarding underwriting and premium risk rating.

Employee Signature: _____ Date Signed: _____