
SJVIA Prospective Member

Data Request Checklist & Questionnaire

Please provide the items below:

- Current census of Employees, Retirees and COBRA participants, presently covered on the health plans, to include the following:**
 - Age or DOB, Gender, Category of coverage (single, two party, family, etc.), zip code
 - Job title or indicate if retiree or COBRA participant
 - Census should indicate line(s) of coverage and differentiate by plan(eg. Medical, Dental, Vision, etc.)

- Complete Benefit Description of each coverage line (e.g. employee booklets or detailed benefit summary)**
 - Medical, Dental, Vision, Basic Life/AD&D, Voluntary Life/AD&D, STD, etc.

- Rates by line of coverage**
 - Current rates by line of coverage
 - Rate history for two prior years if available

- Contribution Strategy** – please provide the employer and employee contribution percentages or amounts.
 - Example: employee coverage – 100%, dependent coverage – 50%

- Significant Claims Information**
 - To the best of your knowledge are there any large ongoing claims situations that could impact the underwriting process? Please provide type of claim, and prognosis to the best of your knowledge (without names).
 - Please complete the attached Prospective Member Questionnaire.

Prospective Member Questionnaire

Group Name: _____ Effective/Renewal Date: _____
 Address: _____ City: _____ Zip Code: _____

Prospective Member Contact Name and Phone Number: _____

Date Questionnaire Submitted: _____

Carrier History for the Past 3 Years: Name of Company:	Period Insured:
1. Current Carrier:	
2. Prior Carrier:	
3. Prior Carrier:	
Eligibility: How many participants are out of state? Active: _____ COBRA: _____ Retiree: _____ How many employees are eligible for health insurance? _____ How many employees are enrolled? _____ How many employees have valid waivers? _____ What type of incentive if any is provided for waivers? If Kaiser is offered, how many eligible employees are covered under Kaiser? _____	Employer Contribution: (Please specify the amount or percentage paid for coverage) For Employees _____% For Dependents _____% Do you use an eligibility vendor or third party administrator for billing and/or eligibility? If so, please identify the provider. _____ Do you promote or offer a wellness program for your employees? Please describe. Is your retiree population blended with or charged the same rate for coverage as your active employees? _____ Please answer the following questions to the best of your knowledge for the persons to be insured including dependents. Provide additional information for any YES responses on a separate page. In the past twelve months, has any person suffered a condition that resulted in expenses of \$25,000 or more? Yes/ No