

LORD & CO. INSURANCE AGENTS

Group Health Pre-Qualification Questionnaire

Section A – Business Information

Company Name: _____

Address: _____

City, State, Zip: _____

Name of Key Contact _____ Email: _____

Phone: _____ Fax: _____

Type of Business: _____ Years in Business: _____

Number of Full-Time, Eligible Employees: _____

Number of Employees to be covered by Group Medical Plan: _____

Any Current COBRA Participants: Yes No If "Yes," how many: _____

Any Retirees currently insured: Yes No If "Yes," how many: _____

Section B – Insurance Carrier Information

Current Group Medical Insurance: Yes No

If "Yes," name of carrier: _____ Renewal Date: _____

Name of prior Group Medical Insurance Carrier: _____

*Please attached recent billing statement AND plan highlights in order to quote

Section C – Additional Information

New employee waiting period: _____

Current employer contribution for employees: _____ Dependents: _____

What co-payments do you desire for the following services:

Doctor Office Visit: \$15 \$20 \$25 \$30

Prescription: \$10 \$15 \$20

Deductible (per person, if any): \$0 \$250 \$500 \$1000

Do you and your employees use hospitals and physicians in the Denton area or in other communities? Please list the hospitals and providers you desire:

Provide census info for employees and dependents to be covered:

	Last Name	Gender	Home Zip Code	DOB	Total # of Dependents	Spouse's DOB (If applicable)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

If any person to be insured has past, current or ongoing health conditions please complete this section:

	Last Name	Employee or Dependent	Date Treatment Begun	Date Released by Physician	Medication Type/Dosage
1					
2					
3					
4					
5					

List any current COBRA participants:

	Last Name	Gender	DOB
1			
2			
3			
4			
5			

How did you get our name? _____

Fax completed form to Margy Sundstrom at 940.387.6962.