



**CIGNA  
Risk Appraisal Questionnaire**

Group Name		Business Phone	
Nature of Business		Number of Years in Business	
1. a. Has Group been previously covered by CIGNA Healthcare of North Carolina, Inc.? <input type="checkbox"/> YES <input type="checkbox"/> NO			
b. List Insurance/HMO carriers for the past 5 years.			
Name	Type(s) of Coverage	Period Covered	
c. Are you continuing coverage with your Insurance/HMO carriers?			
If yes, list carriers:			
2. Please provide your current and renewal health rates below. Attach a copy of your renewal bill or notice.			
Current Rates: Employee \$ _____ Empl+ _____ \$ _____ Empl+ _____ \$ _____ Family \$ _____			
Renewal Rates: Employee \$ _____ Empl+ _____ \$ _____ Empl+ _____ \$ _____ Family \$ _____			
3. Please answer the following questions to the best of your knowledge. NOTE: Please do not give the name of any employee or dependent. Include any person covered with your present plan, COBRA or State Continuation.			
a. Are you aware of any of your employees or dependents with a medical problem or with a history of frequent or recent medical treatment (e.g., cancer, diabetes, cardiovascular disease, substance abuse, mental illness, pregnancy, etc.)			<input type="checkbox"/> YES <input type="checkbox"/> NO
b. Are you aware of any employee or dependent who has been in the hospital, has surgery or treatment pending, or that has been advised that hospitalization, surgery or treatment is needed?			<input type="checkbox"/> YES <input type="checkbox"/> NO
c. Are you aware of any employee or dependent who would be applying for coverage that is mentally or physically disabled?			<input type="checkbox"/> YES <input type="checkbox"/> NO
d. Has any employee been absent for 10 or more days in a row during the past 12 months due to an illness or injury?			<input type="checkbox"/> YES <input type="checkbox"/> NO
e. Are you aware of any employee who is not an active, full time employee or dependent who is home/ hospital confined?			<input type="checkbox"/> YES <input type="checkbox"/> NO
f. Were there any claims that you are aware of that were more than \$5,000 in the last 12 months on any employee or dependent? If yes, please provide the approximate amount paid, medical condition and the likelihood of future expenses?			<input type="checkbox"/> YES <input type="checkbox"/> NO
I represent that to the best of my knowledge the above information is complete and true. I understand that this is not an application for coverage. Any group coverage will not be made effective until a proposal is made to the group, application is made by the group to CIGNA Healthcare and any information given on this form, the application form, or discovered independently is evaluated by CIGNA Healthcare and coverage is approved in writing.			
Group Signature:		Title	Date
Reviewer		Date	
		Accept <input type="checkbox"/>	