**SARA Employer Level Stop Loss Insurance Health Questionnaire**

**Please provide details to questions answered “yes” in the space provided or attach additional sheets if necessary. I understand additional prior plan enrollment information, benefit design information, and history must be evaluated to enroll with this questionnaire. I understand the stop loss\* carrier will rely on the data disclosed below in underwriting the risk covered by the stop loss\* policy; therefore, accuracy in data reported is required. I further understand that remedies may be pursued by the stop loss\* carrier should there be misrepresentation of facts and/or fraud and as allowed by law and the applicable stop loss\* policy.**

1. I agree that with research conducted into information at my disposal as a plan sponsor and/or employer, and to the best of my knowledge, I will answer the following questions for all plan participants and dependents to be covered under this self-funded plan with stop loss\* insurance coverage. [ ]  Yes, I agree [ ]  No If no, please explain:
2. Has anyone missed more than five consecutive workdays in the last 12 months due to injury or illness by them or their dependents? [ ]  Yes [ ]  No If yes, please explain:
3. Has anyone been treated in the past five years or anticipate being treated for a serious illness, immune system disorder, hemophilia, cancer, heart disorder/disease, Hepatitis C, kidney, or organ or tissue disorder/transplant, stroke, AIDS/ARC, mental or nervous disorder, substance abuse or other accident/injury? [ ]  Yes [ ]  No
If yes, please explain:
4. Are there other known potential Shock Loss Claims and/or have any plan participant (employee or dependents) incurred $10,000 or more in accident and/or health and Rx claims within the last 12 months? Shock losses are defined on the Potentially Catastrophic Diagnosis and High-Cost Drug listing page. The diagnosis and high-cost drug lists (see attached on page 3) are intended to help the Proposed Insured identify potential catastrophic claims. [ ]  Yes [ ]  No If yes, please explain:
5. Are there any employees, spouses or dependents who are disabled, or confined in a hospital or treatment facility, or have been pre-certified within the last three months to have an upcoming procedure or treatment, or any employees who are on leave of absence to care for a dependent who will be a plan participant of this health plan? (For employees, disabled means absent from work and/or on leave of absence or Family and Medical Leave Act [FMLA] benefits due to his or her medical condition; for dependents, disabled means unable to perform his or her normal functions of a person of like age. [ ]  Yes [ ]  No If yes, please explain:
6. Has anyone within the last six months been advised to have surgery or does anyone anticipate hospitalization or treatment/outpatient procedure for any other reason? [ ]  Yes [ ]  No

If yes, please explain:

1. Are there any employees who are not performing his or her normal duties due to illness or injury? [ ]  Yes
[ ]  No If yes, please explain:
2. Are any employees or their dependents pregnant and/or considered to be high risk for complications of pregnancy, or carrying multiple fetuses? [ ]  Yes [ ]  No If yes, please explain:
3. Do you have any plan participants who are in their continuation/COBRA election period, or any legally required extended election period? [ ]  Yes [ ]  No If yes, please list all names of the eligible plan participants/members for continuation and those in their election period, including all plan participants and members who elected coverage for continuation:
Plan participants/members must be disclosed here to be included in any stop loss coverage offering that may be made.
4. Have you reviewed your prior carrier bill and COBRA billings and are all members included in the census?
[ ]  Yes [ ]  No If no, please explain:

**Note**: All eligibility and questionnaire information must be complete and accurate. If the information provided is untrue or incomplete and such falsity or incompleteness is material to the risk to be covered by the Plan, and in turn, the stop loss\* carrier, the stop loss\* coverage may be reformed and/or rescinded.

Insurance Fraud Warning:

I declare that I have read this questionnaire in full, researched our employer records available to me as the plan sponsor representative, and that all statements contained in this questionnaire are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information as part of an application for an insurance policy may be subject to criminal and civil penalties.

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Employer Plan Sponsor-Responsible Party Printed Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position

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Employer Plan Sponsor-Responsible Party Signature Date

**ICD-10 Diagnosis List**

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| **A00–B99** | **Infectious Disease** |
| B17.1–B17.11 | Hepatitis C  |
| **C00–D49** | **Neoplasms** |
| C00–C14  | Malignancy of oral cavity pharynx  |
| C15–C26  | Malignant neoplasm of digestive organs  |
| C30–C39  | Malignant neoplasm of respiratory organs  |
| C43–C44  | Melanoma  |
| C50–C50  | Breast Malignancies  |
| C51–C68  | Genitourinary Malignancies  |
| C69–C72  | Malignancies of Nervous System  |
| C81–C96  | Leukemias, Lymphomas and Myelomas  |
| **D50–D89**  | **Hematologic Disorders**  |
| D57.1  | Sickle Cell Anemia  |
| D61.01  | Aplastic Anemia  |
| D66  | Hemophilia/Hereditary Factor VIII Deficiency  |
| D81.0  | Severe Combined Immune Deficiency (SCID)  |
| D82.1  | DiGeorge Syndrome  |
| D83.1  | Immune Deficiency T Cells (AIDS)  |
| D84.1  | Alpha 1-Antitrypsin  |
| **E70–E88**  | **Metabolic Disorders**  |
| E75.22  | Gaucher’s Disease  |
| E84.0  | Cystic Fibrosis  |
| **G00–G99**  | **Diseases of the Nervous System**  |
| G12.21  | Lou Gehrig’s disease (ALS)  |
| G61.0  | Guillain-Barre Syndrome  |
| G91.1  | Obstructive Hydrocephalus  |
| **I00–I99**  | **Diseases of Circulatory System**  |
| I27.0  | Primary Pulmonary Hypertension  |
| I42.0–I42.9  | Cardiomyopathy  |
| I46.9  | Cardiac Arrest  |
| I60.9  | Subarachnoid Hemorrhage  |
| **J00–J99**  | **Disease of Respiratory System**  |
| J96.00–96.92 | Respiratory Failure |
| **K00–K95** | **Disease of Digestive System** |
| K70.0–74.69  | Chronic Liver Disease |
| K72.00–72.91 | Liver Failure |
| **N00–N99** | **Disease Genitourinary System** |
| N18.1–18.9  | Chronic Renal Failure |
| **O00–O9A** | **Pregnancy, Childbirth & Puerperium** |
| O30.10–30.109 | Triplet Pregnancy |
| O30.20–30.209 | Quadruplet Pregnancy |
| O60.00–60.14  | Preterm Labor |
| **P00–P96** | **Perinatal Conditions** |
| P07.00–07.36  | Preterm Infant |
| P22.0  | Respiratory Distress Syndrome of Newborn |
| **Q00–Q99** | **Congenital Malformations** |
| Q20–Q28 | Congenital Heart Diseases |
| Q39.0–39.4 | Tracheoesophageal Fistula |
| Q89.7  | Multiple Anomalies |
| **S00–T88**  | **Injury, Poisoning and Trauma** |
| S06.0–06.9  | Brain Injuries |
| S12–S14  | Spinal Cord Injuries |
| S88 | Amputations |
| T07 | Multiple Trauma Injuries |
| T20–T32  | Burns |
| T79 | Early Complications of Trauma |
| T86.00–86.09  | Graft vs. Host Disease |
| T86.90–86.99 | Complications of Transplants  |
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| **High-Cost Drugs** |

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| A high-cost drug is defined as a drug for which monthly costs exceed approximately $10,000. **Examples:**  Avastin, Iclusig, Taltz, Berinert, Kalbitor, Technivie,Cinryze, Kalydeco, Tyvaso, Daklinza, Keytruda, Uptravi, Epclusa, Kynamro, Entavis, Firazyr, Lumizyme, Viekira, Gleevec (imatinib), Opdivo, H.P. Acthar, Orkambi, Yervoy, Harvoni, Soliris, Zaltrap, Humira, Sovaldi, Zepatier, Ibrance, Stelara Conditions leading to use of high-cost drugs may include: enzyme deficiencies (genetic mutations, Hereditary Angio Edema, Hunter’s Syndrome and other), cancers, Cystic Fibrosis, MS, Nephrotic Syndrome, Psoriasis and inflammatory conditions, Hepatitis C, Hemophilia A,B,C, Hemolytic Uremia Syndrome, MDS, Narcolepsy and Pulmonary Arterial Hypertension. |