



Attach a Summary of Benefits for each Plan Design currently offered to employees and/or complete the table below showing Copayments/Coinsurance (if any) for each of the following:

In-Plan (Participating Providers)			Out-of-Plan (Non-Participating Providers)		
Annual Deductible Single/Family	\$	F	Annual Deductible Single/Family	\$	F
Annual Maximum Out-of-Pocket	\$	F	Annual Maximum Out-of-Pocket	\$	F
Inpatient Services (Per Day or Per Admit)	\$	%	Inpatient Services (Per Day or Per Admit)	\$	%
Primary Care Physician Office Visits	\$	%	Primary Care Physician Office Visits	\$	%
Specialist Office Visits	\$	%	Specialist Office Visits	\$	%
Hospital Emergency Room	\$	%	Hospital Emergency Room	\$	%
Outpatient Physician Services	\$	%	Outpatient Physician Services	\$	%
Mental Health/Chemical Dependency:			Mental Health/Chemical Dependency:		
Individual Outpatient Therapy	\$	%	Individual Outpatient Therapy	\$	%
Group Outpatient Therapy	\$	%	Group Outpatient Therapy	\$	%
Inpatient MH/CD	\$	%	Inpatient MH/CD	\$	%
Day Treatment MH/CD	\$	%	Day Treatment MH/CD	\$	%
Annual Max. or # of Days allowed	IP	OP	Annual Max. or # of Days allowed	IP	OP
Transplant Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Transplant Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Infertility Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infertility Coverage	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prescription Drugs:			Prescription Drugs:		
Generic equivalent 30 day supply	\$	%	Generic equivalent 30 day supply	\$	%
Brand name 30 day supply	\$	%	Brand name 30 day supply	\$	%
Up to 90 day supply Generic	\$	%	Up to 90 day supply Generic	\$	%
Vision - Annual Eye Exam - Copay Amt.			Vision - Annual Eye Exam - Copay Amt.		
Chiropractic Services Covered	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chiropractic Services Covered	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pre-existing Conditions Covered	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pre-existing Conditions Covered	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Broker/Consultant/Agent Commissions. If a Broker/Consultant/Agent represents Employer, and if mutually agreed upon by Employer and Welborn Health Plans, we will provide payment to Broker/Consultant/Agent for services rendered on behalf of the Employer. An agent of record letter must be provided by the Employer to Welborn indicating that the agent is representing the Employer and eligible for payment.

Broker/Agent: _____ **Phone:** _____ **Fax:** _____



EMPLOYER GROUP MEDICAL QUESTIONNAIRE

Please answer the following questions to the best of your knowledge for the persons to be insured. Give details to questions answered "yes" in the space provided. If more room is needed, use the back of this form.

1. Has any employee or eligible dependent been treated for a serious illness that required hospitalization in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has any employee or eligible dependent had a medical claim totaling \$10,000 or more in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Has any employee or eligible dependent undergone open-heart surgery or received significant cardiac testing at anytime in the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any employee or eligible dependent been advised to have surgery or diagnostic testing in the last six months or anticipate hospitalization for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are there any current or former employees or dependents on Cobra?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any employee or eligible dependent received a transplant or been told they are a possible transplant candidate?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are there any employees or eligible dependents who are incapacitated (disabled) or confined in a hospital or treatment center?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Has any employee or eligible dependent been medically diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS") or tested positive for antibodies to the AIDS virus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Has any employee or eligible dependent been treated for a serious illness or injury (i.e. cancer, diabetes, cardiovascular disease, substance abuse, mental illness, head injury, pre-mature birth, Alzheimer's Disease, Hodgkin's Disease, Leukemia, Liver, Kidney, Bladder or Prostate Disorder, Asthma, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the questions above, please provide the following information for each individual.

Question #	Gender	Age	Health Condition	Current Status	Prognosis

The applicant hereby certifies that the information on this form is complete and true to the best of their knowledge. Applicant understands that any misrepresentation, intentional or otherwise, as to the presence or absence of pre-existing medical conditions, impairments or diseases will void group membership and rights to benefits. The issuance of a group policy by Welborn Health Plans will depend on underwriting evaluation of this form, Individual medical questionnaires and other relevant information as may be requested. Changes in health status after this questionnaire is submitted, but prior to acceptance, must be reported to Welborn Health Plans.

Employer Signature: _____

Date: _____

Print Name: _____

Title: _____

Return Completed form to:

WELBORN HEALTH PLANS - Marketing Dept.
101 S.E. Third Street
Evansville, IN 47708
Phone 812-773-0370 ♦ Fax 716-541-6335