

COMPANY NAME: _____

ADDRESS _____

PHONE _____ CONTACT PERSON _____

Has your company had coverage with either PHP or PIC within the last 3 years? _____ if so give dates: _____

Please list the number of employees working outside the PIC service areas. _____

Number of former employees / dependents currently under COBRA and effective dates. _____

To the best of your knowledge:

1. Is any employee not actively at work or working reduced hours due to illness or injury? _____ If yes, give details. _____
2. Has any employee, dependent or COBRA eligible incurred claims greater than \$50,000 in the last 12 months? _____
3. Has any employee, dependent or COBRA eligible had or is any anticipating an organ or bone marrow transplant: If yes give details. _____
4. Has any employee, dependent or COBRA eligible had cancer, heart disease, diabetes, AIDS, HIV, liver disease (including hepatitis) or chronic mental illness? _____ If yes, give details _____
5. Is any employee, dependent or COBRA eligible currently pregnant? _____ If yes, list due dates and any complications if known give details _____
6. Does any employee, dependent or COBRA eligible have a physical or mental condition which may lead to treatment, surgery, or hospitalization? _____ if yes, give details. _____
7. Are all employees and owners covered by Worker's Compensation? _____ if not, please identify those not covered. _____

I certify that the information provided above is accurate and complete to the best of my knowledge. Any information omitted, misrepresented or incorrectly stated on this form may, at the sole discretion of Presbyterian Insurance Company, result in group disenrollment as of the original effective date. I acknowledge that my group will not receive coverage until final approval is issued by Presbyterian Insurance Company.

Group Owner, officer, or administrator's signature: _____

Title _____ Date _____