



Risk Appraisal Questionnaire
(to be completed by the Employer)



Vista Healthplan, Inc. and Vista Healthplan of South Florida, Inc. (referred to as "VISTA") and Coventry Health and Life Insurance Company (referred to as "Coventry") rely on the Employer's responses to the Risk Appraisal Questionnaire ("RAQ") for underwriting purposes.

Medical Profile

The information entered in this RAQ is complete, true and correct to the best of my knowledge for all employees and dependents (proprietors, partners, corporate officers, employees, spouses and dependent children) currently enrolled in a health plan. If accepted for coverage, any misrepresentation or omissions in answering this RAQ may result in (i) rescission of coverage and voiding of the contract back to the original effective date; (ii) termination of coverage, or (iii) substandard rating in accordance with Coventry/VISTA guidelines.

1. Have any eligible employees or dependents been diagnosed or treated by a medical professional for any of the following during the past five years: [ ] Yes [ ] No

Table with 4 columns of medical conditions: Anemia, Aneurysm, Brain disorder, Cancer, Chronic Lung Disorder, Congenital Disorders, Connective Tissue Disorder, Diabetes, Growth Hormones, Heart Disease, Intestinal Disorders, Kidney Disease / Kidney Failure / Renal disorder, Liver Disorders, Lung or pulmonary disorder, Lupus, Mental Health / Nervous Disorder / Addiction-related disorder, Multiple Sclerosis, Muscular Dystrophy, Organ Transplants, Paralysis, Seizures, Stroke.

- 2. Are any eligible employees or dependents currently pregnant? If yes, list approximate number: [ ] Yes [ ] No
3. Have any eligible employees or dependents been hospitalized or had any surgical operations during the past 5 years? [ ] Yes [ ] No
4. Is any eligible employee or dependent anticipating a surgical procedure, inpatient medical or psychiatric hospital admission? [ ] Yes [ ] No
5. Have any eligible employees been absent from work or confined to the home or incapacitated for more than 2 consecutive weeks due to illness or injury during the past 5 years? [ ] Yes [ ] No
6. Have any eligible employees or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next 6 months by a medical professional? [ ] Yes [ ] No
7. Are any eligible employees or dependents receiving disability benefits of any type including Social Security Income, Workers' Compensation, Medicare or Medicaid? [ ] Yes [ ] No
8. Have any eligible employee or dependent ever tested positive for human immunodeficiency virus (HIV) or been diagnosed as having aids related complex / conditions (ARC), acquired immunodeficiency syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency? [ ] Yes [ ] No
9. Has any eligible employee incurred medical expenses in excess of \$10,000 during the last twelve (12) months? [ ] Yes [ ] No

If you have answered "Yes" to any of the questions above, please provide the requested information for each individual. If necessary, use additional sheets of paper.

Table with 9 columns: Question #, Employee, Dependent, Age, Date of Treatment / Date of Recovery, Nature of Condition, Name of Medication, \$ Amount of Claims, Prognosis Current Treatment.

Employer shall notify Coventry/VISTA promptly of any changes in this information that may affect the eligibility of employees or dependents, including the addition of any newly eligible employees or dependents. Prior to the effective date of policy coverage, Employer shall immediately notify Coventry/VISTA's Underwriting Department of any changes in the health status of an eligible employee or dependent including any inpatient hospital admissions that occurred any time after the date of your Application, but prior to the effective date of the policy issuance.

I understand that the Certificate of Insurance/Certificate of Coverage or Schedule of Benefits and other documents, notices and communications regarding the health benefit plan indicated on this Application may be transmitted electronically to me and to Employer's employees.

I certify that all information and statements furnished by me are true and complete to the best of my knowledge and includes any employees who have elected COBRA or State Continuation of Coverage. I am duly authorized to execute this RAQ.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Employer Name: \_\_\_\_\_ Tax ID: \_\_\_\_\_ Phone: \_\_\_\_\_
Address: \_\_\_\_\_
Authorized Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_
Title (must be owner or officer): \_\_\_\_\_ Date: \_\_\_\_\_