



SUPPLEMENTAL CLAIMS INFORMATION

Please answer the following questions to the best of your knowledge. If the answer is “yes,” please explain below or on a separate page. Refer to the appropriate question number (e.g., “A”) and give details.

		Yes	No
A.	Did any employee or dependent suffer a condition which resulted in total claims of \$10,000 or more during the last 12 months? If yes, indicate diagnosis/prognosis and \$ amounts below.		
B.	Are there any employees or dependents who have been or expect to be treated for a serious medical condition?		
C.	Is any dependent child over age 19 incapable of self-support because of a physical or mental disability?		
D.	How many employees and/or dependents are being covered under COBRA continuation?		
E.	To your knowledge, are there any serious medical problems on the COBRA group?		
F.	Is anyone presently covered under COBRA totally disabled?		
G.	Is anyone presently covered under the extended benefits provision of the current plan?		
H.	Is coverage continued under your present or former plan for any retirees or other employees and/or dependents (other than those noted above) no longer employed full time?		
I.	Are any employees or dependents presently disabled? (For an employee that means: Is he or she absent from work due to injury or sickness? For a dependent that means: Is he or she unable to perform the usual and customary activities of a person of like age and sex in good health?)		
J.	For how many months is coverage provided under the extended disability provision of the current plan?		
Explanations:			
Group Leader		Date:	
Group Name		Phone:	
Agent/Agency		Fax:	