



**Associated Employers Trust
Group Health Risk Questionnaire**

Wells Fargo Insurance Services

Group Name: _____

HEALTH/WELLNESS PROMOTION

1. Do you offer injury prevention classes such as back care, repetitive motion disorders, proper lifting and use of heavy equipment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you have a drug/alcohol screening program?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Please check any of the following your company provides:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> cholesterol screenings <input type="checkbox"/> on-site flu shots		
<input type="checkbox"/> blood glucose screenings <input type="checkbox"/> blood pressure checks		

ADVERSE RISK FACTORS

4. How many employees are currently on medical leave of absence or are absent from work for medical reasons for more than 3 consecutive workdays?	_____
5. How many participants or covered dependents are pregnant?	_____
6. Has any participant or covered dependent been treated for or is expected to be treated for a serious illness or injury (e.g., cancer, AIDS, cardiovascular diseases, renal disease, pulmonary disease, etc.)? If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
7. Has any participant or covered dependent been treated for or is expected to be treated for an ongoing illness (e.g., juvenile diabetes, substance abuse, mental illness, multiple sclerosis, rheumatoid arthritis, etc.)? If so, please clarify with dates, prognosis, follow-up, on-going treatments, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>
8. How many persons are presently covered under the Continuation of Medical Benefits as defined under COBRA who will probably continue coverage under this plan?	_____
9. Has any participant or covered dependent had in the past 12 months or expect to have in the next 12 months a health claim of \$10,000 or more? If you are unsure as to the cost of the individual's potential medical expenses, please list the conditions to the best of your knowledge. If so, please clarify with dates, diagnosis, prognosis, follow-up care, on-going treatments, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No <hr/> <hr/> <hr/>

Broker Signature	Group Representative Signature
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Date: _____