Oxford Health Plans®

Account Evaluation Form

Please fill out the information below to the best of your knowledge. **Do not** seek any additional information directly from your employees.

Company Name:____

Employer Questions - If the answer is "Yes" for any of the following, please give explanation below.

A. Have any employees or any other family members incurred medical and or hospital expenses of $10,000 or more in the past two years? ❑ Yes ❑ No

B. Are any employees or dependents currently covered due to 1)COBRA/state continuance, 2)Extension of Benefits, or 3.)Short or Long Term Disability [STD-LTD]? ❑ Yes ❑ No

C. How many employees or dependents are pregnant? ________________________

D. In the past two years, have any employees or any other family member(s) been confined to a hospital for a mental/ nervous disorder, alcohol or drug abuse, a congenital disorder or for a defect existing from birth? ❑ Yes ❑ No

E. In the past two years, have any employees or any other family member(s) had treatment, attention, or advice from a physician for cancer, heart disease or disorder, stroke, kidney/bladder disease, diabetes, liver disorder, high blood presure, brain disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol or drug abuse or any other serious medical order? ❑ Yes ❑ No

F. Have any employees and/or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next six months? ❑ Yes ❑ No

Additional Information for Questions A-F

Diagnosis	Age	Dollar amount of claim and/or length of stay	Current Condition	Date	Related Information

COBRA and/or STD-LTD Information

Reason for Continuance or disability	Age	Health Condition	Date Continuance or Disability Will End

Broker/Agent Signature:____ Date:____________

Customer Signature:____ Date:____________