Roger Hicks & Associates Group Insurance, Inc.

GROUP APPRAISAL FORM

Company Name: ____

Please answer the following questions to the best of your knowledge and belief for employees, their dependents and any individuals eligible for coverage under you current health plan(s) or COBRA. Attach additional information as needed.

1. Have expenses in excess of $5,000 been incurred for any medical treatment during the last two years by any individual eligible for coverage under this proposed plan? If yes, provide details below.			☐ Yes ☐ No
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment Received	
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment Received	

2. Are you aware of any employee or dependent who has hospitalization, surgery or treatment pending, or who has been advised that hospitalization, surgery or treatment is needed? If yes, provide details below.			☐ Yes ☐ No
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment Pending	
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment Pending	

3. Does any eligible person currently have a serious illness (including, but not limited to: cancer, heart disease, diabetes, substance abuse, mental illness, aids or any immune deficiency disease, spina bifida, kidney disease, cystic fibrosis or any other progressive disabling condition?) If yes, provide details below.			☐ Yes ☐ No
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment/Medication Pending	
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment/Medication Pending	

4. Are any employees or dependents currently hospitalized or incapacitated due to illness or accident? If yes, provide details below.			☐ Yes ☐ No
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment/Medication	
Employee ☐	Dependent ☐	Diagnosis and Prognosis	
Date of Diagnosis		Treatment/Medication	

5. Are any persons eligible for coverage currently pregnant?	☐ Yes ☐ No
Due Date(s)	

I hereby certify that, to the best of my knowledge, the information provided herein is complete and true. I understand that carriers who write business in Oklahoma rely on the information provided in this questionnaire and reserve the right to retroactively cancel the group's policy if fraudulent or incomplete information is provided.	
Authorized Signature	Date

PLEASE RETURN BY FAX TO (405) 478-3636