



## ARA Employer Level Stop Loss Insurance Health Questionnaire

Please provide details to questions answered “yes” in the space provided or attach additional sheets if necessary. I understand additional prior plan enrollment information, benefit design information, and history must be evaluated to enroll with this questionnaire. I understand the stop loss\* carrier will rely on the data disclosed below in underwriting the risk covered by the stop loss\* policy; therefore, accuracy in data reported is required. I further understand that remedies may be pursued by the stop loss\* carrier should there be misrepresentation of facts and/or fraud and as allowed by law and the applicable stop loss\* policy.

1. I agree that with research conducted into information at my disposal as a plan sponsor and/or employer, and to the best of my knowledge, I will answer the following questions for all plan participants and dependents to be covered under this self-funded plan with stop loss\* insurance coverage.

Yes, I agree.     No                      If No, please explain below:

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2. Has anyone missed more than five consecutive workdays in the last 12 months due to injury or illness by them or their dependents?

Yes                       No                      If Yes, please explain below:

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3. Has anyone been treated in the past five years or anticipate being treated for a serious illness, immune system disorder, hemophilia, cancer, heart disorder/disease, Hepatitis C, kidney, or organ or tissue disorder/transplant, stroke, AIDS/ARC, mental or nervous disorder, substance abuse or other accident/injury?

Yes                       No                      If Yes, please explain below:

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4. Are there other known potential Shock Loss Claims and/or have any plan participant (employee or dependents) incurred \$10,000 or more in accident and/or health and Rx claims within the last 12 months? Shock losses are defined on the Potentially Catastrophic Diagnosis and High-Cost Drug listing page. The diagnosis and high-cost drug lists (see attached on page 3) are intended to help the Proposed Insured identify potential catastrophic claims.

Yes                       No                      If Yes, please explain below:

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5. Are there any employees, spouses or dependents who are disabled, or confined in a hospital or treatment facility, or have been pre-certified within the last three months to have an upcoming procedure or treatment, or any employees who are on leave of absence to care for a dependent who will be a plan participant of this health plan? (For employees, disabled means absent from work and/or on leave of absence or Family and Medical Leave Act [FMLA] benefits due to his or her medical condition; for dependents, disabled means unable to perform his or her normal functions of a person of like age.)

Yes                       No                      If Yes, please explain below:

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\* Stop Loss is also known as Excess Loss



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6. Has anyone within the last six months been advised to have surgery or does anyone anticipate hospitalization or treatment/outpatient procedure for any other reason?

Yes

No

If Yes, please explain below:

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7. Are there any employees who are not performing his or her normal duties due to illness or injury?

Yes

No

If Yes, please explain below:

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8. Are any employees or their dependents pregnant and/or considered to be high risk for complications of pregnancy, or carrying multiple fetuses?

Yes

No

If Yes, please explain below:

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**Note:** All eligibility and questionnaire information must be complete and accurate. If the information provided is untrue or incomplete and such falsity or incompleteness is material to the risk to be covered by the Plan, and in turn, the stop loss\* carrier, the stop loss\* coverage may be reformed and/or rescinded.

Insurance Fraud Warning:

I declare that I have read this questionnaire in full, researched our employer records available to me as the plan sponsor representative, and that all statements contained in this questionnaire are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand any person who includes any false or misleading information as part of an application for an insurance policy may be subject to criminal and civil penalties.

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Company Name

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Employer Plan Sponsor-Responsible Party **Printed Name**

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Position

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Employer Plan Sponsor-Responsible Party **Signature**

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Date

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## ARA Employer Level Stop Loss Insurance Health Questionnaire

### ICD-10 Diagnosis List

<b>A00–B99</b>	<b>Infectious Disease</b>	<b>P00–P96</b>	<b>Perinatal Conditions</b>
B17.1–B17.11	Hepatitis C	P07.00–07.36	Preterm Infant
<b>C00–D49</b>	<b>Neoplasms</b>	P22.0	Respiratory Distress Syndrome of Newborn
C00–C14	Malignancy of oral cavity pharynx	<b>Q00–Q99</b>	<b>Congenital Malformations</b>
C15–C26	Malignant neoplasm of digestive organs	Q20–Q28	Congenital Heart Diseases
C30–C39	Malignant neoplasm of respiratory organs	Q39.0–39.4	Tracheoesophageal Fistula
C43–C44	Melanoma	Q89.7	Multiple Anomalies
C50–C50	Breast Malignancies	<b>S00–T88</b>	<b>Injury, Poisoning and Trauma</b>
C51–C68	Genitourinary Malignancies	S06.0–06.9	Brain Injuries
C69–C72	Malignancies of Nervous System	S12–S14	Spinal Cord Injuries
C81–C96	Leukemias, Lymphomas and Myelomas	S88	Amputations
<b>D50–D89</b>	<b>Hematologic Disorders</b>	T07	Multiple Trauma Injuries
D57.1	Sickle Cell Anemia	T20–T32	Burns
D61.01	Aplastic Anemia	T79	Early Complications of Trauma
D66	Hemophilia/Hereditary Factor VIII Deficiency	T86.00–86.09	Graft vs. Host Disease
D81.0	Severe Combined Immune Deficiency (SCID)	T86.90–86.99	Complications of Transplants
D82.1	DiGeorge Syndrome		
D83.1	Immune Deficiency T Cells (AIDS)		
D84.1	Alpha 1-Antitrypsin		
<b>E70–E88</b>	<b>Metabolic Disorders</b>		
E75.22	Gaucher's Disease		
E84.0	Cystic Fibrosis		
<b>G00–G99</b>	<b>Diseases of the Nervous System</b>		
G12.21	Lou Gehrig's disease (ALS)		
G61.0	Guillain-Barre Syndrome		
G91.1	Obstructive Hydrocephalus		
<b>I00–I99</b>	<b>Diseases of Circulatory System</b>		
I27.0	Primary Pulmonary Hypertension		
I42.0–I42.9	Cardiomyopathy		
I46.9	Cardiac Arrest		
I60.9	Subarachnoid Hemorrhage		
<b>J00–J99</b>	<b>Disease of Respiratory System</b>		
J96.00–96.92	Respiratory Failure		
<b>K00–K95</b>	<b>Disease of Digestive System</b>		
K70.0–74.69	Chronic Liver Disease		
K72.00–72.91	Liver Failure		
<b>N00–N99</b>	<b>Disease Genitourinary System</b>		
N18.1–18.9	Chronic Renal Failure		
<b>O00–O9A</b>	<b>Pregnancy, Childbirth &amp; Puerperium</b>		
O30.10–30.109	Triplet Pregnancy		
O30.20–30.209	Quadruplet Pregnancy		
O60.00–60.14	Preterm Labor		

### High-Cost Drugs

A high-cost drug is defined as a drug for which monthly costs exceed approximately \$10,000.

#### Examples:

Avastin, Iclusig, Taltz, Berinert, Kalbitor, Technivie, Cinryze, Kalydeco, Tyvaso, Daklinza, Keytruda, Uptravi, Epclusa, Kynamro, Entavis, Firazyr, Lumizyme, Viekira, Gleevec (imatinib), Opdivo, H.P. Acthar, Orkambi, Yervoy, Harvoni, Soliris, Zaltrap, Humira, Sovaldi, Zepatier, Ibrance, Stelara

Conditions leading to use of high-cost drugs may include: enzyme deficiencies (genetic mutations, Hereditary Angio Edema, Hunter's Syndrome and other), cancers, Cystic Fibrosis, MS, Nephrotic Syndrome, Psoriasis and inflammatory conditions, Hepatitis C, Hemophilia A,B,C, Hemolytic Uremia Syndrome, MDS, Narcolepsy and Pulmonary Arterial Hypertension.

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