UNIVERSAL CARE RISK EVALUATION FORM

Groups of 20 or more employees must complete this form

Universal Care®
Healthcare you can feel good about.
1600 E. Hill Street ▪ Signal Hill, CA 90806
(800) 635-6668 ext. 4848
www.universalcare.com

Name of Employer

In order to evaluate an application properly,

Universal Care requires the Employer to answer the questions below. This form should be filled out by the person responsible for operation of the current benefit plan. Please answer each question to the best of your knowledge with respect to **all** eligible employees and dependents that you intend to have covered under Universal Care's plan, **including** those that will be on continuation of benefits under COBRA.

All medical information relating to individuals shall be kept confidential by Universal Care and will be used solely for the purposes of underwriting this policy.

	Yes	No
1. Has any employee or dependent been hospitalized during the past 12 months?	☐	☐
2. Has any employee or dependent had cancer, heart disease or heart disorder, stroke, kidney disorder, diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions or any other medical condition during the past 2 years?	☐	☐
3. Has any employee or dependent been unable to perform his/her usual duties or activities for more than 10 consecutive days during the past 12 months?	☐	☐
4. Are any employees or dependents currently pregnant? If yes, please indicate how many: ☐	☐	☐

If you answered "YES" to any of the questions, 1 through 4, then please provide the additional information requested below for each individual.

Attach an additional sheet if more space is necessary.

Name	Age	Indicate Whether Employee or Dependent	Sex	Nature of Illness	Length of Disability	Current Health Status
		☐ Employee ☐ Dependent			Mo. Yr. - Mo. Yr.	
		☐ Employee ☐ Dependent			Mo. Yr. - Mo. Yr.	
		☐ Employee ☐ Dependent			Mo. Yr. - Mo. Yr.	
		☐ Employee ☐ Dependent			Mo. Yr. - Mo. Yr.	

Is any employee or dependent currently on an extension of benefits under COBRA? ☐ *Yes* ☐ *No*
If so, please provide the following information on all such individuals:

Name	Age	Indicate Whether Employee or Dependent	Sex	Effective Date of COBRA	Current Health Status
		☐ Employee ☐ Dependent		Month Year	
		☐ Employee ☐ Dependent		Month Year	
		☐ Employee ☐ Dependent		Month Year	
		☐ Employee ☐ Dependent		Month Year	

I certify that the above answers are correct to the best of my knowledge:

Attach an additional sheet if more space is necessary.

Signature of Person Filling Out This Form	Date	Title	Date
	Month Day Year		Month Day Year
Signature of Agent or Broker	**Date**	**Universal Care Underwriting Dept.**	**Date**
	Month Day Year		Month Day Year

Universal Care reserves the right to withdraw, decline or refuse its quoted rates within 30 days from the date this form is signed by the Universal Care Underwriting Department.