10421 South Jordan Gateway Suite 400
South Jordan Utah 84095
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# RISK EVALUATION

Group Name _____ Effective Date _____

*Please answer each question to the best of your knowledge with respect to all eligible employees (EE) and dependents (DEP) for the period of the last 3 years (including those that will be on COBRA).*

| | | Yes | No |
|---|---|---|---|
| 1. | Any EE/DEP with frequent medical problems/treatment? | ☐ | ☐ |
| 2. | Any EE/DEP currently hospitalized, with hospitalization or surgery pending? | ☐ | ☐ |
| 3. | Any EE/DEP been advised that hospitalization or surgery is needed? | ☐ | ☐ |
| 4. | Any EE/DEP with AIDS, Cancer, Heart Disease or Diabetes? | ☐ | ☐ |
| 5. | Any EE/DEP with a mental/physical disorder? | ☐ | ☐ |
| 6. | Any EE/DEP with current disabilities, or anyone who has missed 10 or more days of work in the last 12 months? | ☐ | ☐ |
| 7. | Any EE/DEP have claims within in the last 3 years in excess of $5,000? | ☐ | ☐ |

***IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, PLEASE DESCRIBE THE CONDITION(S) BELOW. DEPENDING ON THE CONDITION(S) WE MAY HAVE YOU COMPLETE AN ALTIUS STATEMENT OF HEALTH.***

Please list any known pregnancies among employees/dependents:

| Name | Anticipated Abnormalities (e.g., Premature, Twins, Etc.) | Due Date | Age |
|---|---|---|---|
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**SIGNATURE** **TITLE** **DATE**