



## Group Life Risk Analysis Questionnaire

This Risk Analysis Questionnaire must be submitted and accepted by Continental Assurance Company prior to coverage being bound.

Employer Name:	
Address:	
City, State Zip:	

Please answer the following two questions to the best of your knowledge with regard to all employees and their dependents (if Dependent Coverage is applicable).

1) Have any eligible employees or dependents been treated for a serious medical condition during the past 12 months?  Yes  No

If yes, please provide details.

2) Are any eligible employees or dependents presently disabled?  Yes  No

If yes, please provide details.

**NOTE:** Completion of a Supplemental Questionnaire may be necessary if "yes" was answered to either of the above questions.

Completed by: \_\_\_\_\_ Title: \_\_\_\_\_

Date: \_\_\_\_\_

An employer who knowingly and with intent to defraud or deceive an insurer when completing this form may be guilty of insurance fraud.



## Group Life Supplemental Questionnaire

This Supplemental Questionnaire must be submitted and accepted by Continental Assurance Company prior to coverage being bound.

<b>Employer Name:</b>	
<b>Address:</b>	
<b>City, State Zip:</b>	

Please answer the section of questions that are applicable. Please use a separate page for each person. If additional space is needed you may attach a separate sheet.

### Cancer/Tumor

1)	What is the age of the person with this condition?
2)	Was the tumor described as benign or malignant?
3)	What part of the body was involved?
4)	When was the tumor diagnosed?
5)	Give the staging/grade or details of the spread of the tumor.
6)	Has the tumor been removed or eradicated? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?
7)	What was the kind of treatment received? (Surgical removal, radiation, chemotherapy or combination)
8)	Has there been any recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No
9)	Have there been any previous tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No

### Coronary Artery Disease

1)	What is the age of the person with this condition?
2)	Was there an actual heart attack(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
3)	Was Cardiac Catheterization completed? If yes, what was the extent of the obstruction? Ejection fraction, if known:
4)	Was coronary artery bypass or angioplasty performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? If bypass was performed, number of vessel bypasses?
5)	If surgery has not been performed, has it been recommended or scheduled? <input type="checkbox"/> Yes <input type="checkbox"/> No
6)	Date the employee returned or is expected to return to work? _____ Any restrictions on activities? <input type="checkbox"/> Yes <input type="checkbox"/> No Is there a formal rehabilitation program? <input type="checkbox"/> Yes <input type="checkbox"/> No
7)	Please provide a list of all medications currently being taken.
8)	Has there been regular medical follow up for the condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
9)	Is there any other cardiovascular disorder, diabetes or other medical condition involved? <input type="checkbox"/> Yes <input type="checkbox"/> No
10)	Does the person smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Completed by:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Date:** \_\_\_\_\_

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