



A UnitedHealthcare Company

Account Evaluation Form

Please fill out the information below to the best of your knowledge. **Do not** seek any additional information directly from your employees.

Company Name: _____

Employer Questions - If the answer is "Yes" for any of the following, please give explanation below.

- A. Have any employees or any other family members incurred medical and or hospital expenses of \$10,000 or more in the past two years? Yes No
- B. Are any employees or dependents currently covered due to 1)COBRA/state continuance, 2)Extension of Benefits, or 3.)Short or Long Term Disability [STD-LTD]? Yes No
- C. How many employees or dependents are pregnant? _____
- D. In the past two years, have any employees or any other family member(s) been confined to a hospital for a mental/nervous disorder, alcohol or drug abuse, a congenital disorder or for a defect existing from birth? Yes No
- E. In the past two years, have any employees or any other family member(s) had treatment, attention, or advice from a physician for cancer, heart disease or disorder, stroke, kidney/bladder disease, diabetes, liver disorder, high blood pressure, brain disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS related conditions, alcohol or drug abuse or any other serious medical order? Yes No
- F. Have any employees and/or dependents been advised to undergo medical treatment, surgical operations, diagnostic testing or hospitalization in the next six months? Yes No

Additional Information for Questions A-F

Diagnosis	Age	Dollar amount of claim and/or length of stay	Current Condition	Date	Related Information

COBRA and/or STD-LTD Information

Reason for Continuance or disability	Age	Health Condition	Date Continuance or Disability Will End

Broker/Agent Signature: _____

Date: _____

Customer Signature: _____

Date: _____