SEXTANT
SELF FUNDING, LLC
STOP LOSS PROGRAM MANAGEMENT GUIDANCE

Sextant Select
The alternative underwriting solution to
Fully Insured Group Health Plans

Employee Self-Funded Health Plan Questionnaire

Participant Information

Participant: **Employer** _____

Name _____

Address _____ C/S/Z_____

Contact phone number _____ Birth Date _____Date of Hire _____

Will you be enrolling in your employer's health plan? Yes _____ No _____ (if you selected yes, please complete form)

If no, please indicate reason: Spouse's Plan _____ Not Eligible _____ Do Not Want Coverage _____

(Answer all questions for yourself and eligible enrolling family members. Include additional sheets for detailed explanations or additional dependents. All questions MUST be answered or the form may not be accepted)

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Enrollment Info:

Relation to Employee	Name	Soc. Sec. Number	Gender M/F	D. O. B.	Height Feet/Inches	Weight	Home Zip Code	Smoke Within Last Year (Y/N)
Employee								
Spouse								
Child								
Child								
Child								
Child								
Child								

Pregnancy:

Is any covered person pregnant? Yes _____ No _____

A. Due date is _____

B. Is this a High Risk Pregnancy, any complications or bleeding? Yes _____ No _____

C. Previous C-Section or Pre-Term Birth? Yes _____ No _____

D. Are Multiple Births Expected? Yes _____ No _____

Medical Conditions and Treatments:

1. Cancer: Yes___ No___ If yes: Location and Type _____ Stage: 1. __ 2. __ 3.__ 4.__ Remission? Date:_____	**2. Cardiac**: Yes__ No__ Heart Attack: Yes __ No __ Bypass 1 Vessel: Yes __ No __ Angioplasty 1 Vessel: Yes__ No __ Bypass Multiple: Yes __ No __ Angioplasty Multiple: Yes __ No __	**3. Diabetes:** Yes __ No __ Type: _____ If yes, 3 most recent HbA to/Fasting blood sugar levels 1. _____ 2. _____ 3. _____	**4. High Cholesterol:** Yes __ No __ If yes, 3 most recent readings 1. ____ 2. ____ 3. ____	**5. High Blood Pressure:** Yes ___ No ___ If yes, 3 most recent readings 1. _____ 2. _____ 3. _____

6. Arthritis (rheumatoid, osteo, psoriatic, gout) Yes ____ No ____	**17. Muscular Disorder** Yes ____ No ____
7. Autoimmune Disease (lupus, MS, anemia) Yes ____ No ____	**18. Respiratory** (asthma, allergies, pneumonia, COPD, emphysema, bronchitis) Yes ____ No ____
8. Back Disorder (disk disease, spinal fusion, strain, etc) Yes ____ No ____	**19. Stomach (**ulcer, acid reflux, GERD) Yes ____ No ____
9. Benign Growth Yes ____ No ____	**20. Substance dependency** (alcohol, drugs) Yes ____ No ____
10. Bowel (irritable bowel IBS, Crohn's, ileitis) Yes ____ No ____	**21. Transplants** (list organs) Yes ____ No ____
11. Circulatory System (stroke, vascular disease) Yes ____ No ____	**22. Prescription Meds** (current) Yes ____ No ____
12. Immunodeficiency (AIDS, HIV, hemophilia) Yes ____ No ____	**23. Serious Illness** (treatment, hospitalized, surgery) Yes ____ No ____
13. Kidney Disorder (nephritis, renal failure) Yes ____ No ____	**24. Is anyone currently:** Hospitalized, confined in a treatment facility or incapable of self-support Yes ____ No ____
14. Liver Disease (cirrhosis, hepatitis A, B, C, E) Yes ____ No ____	**25. Is any of the following pending:** Medical Treatment or diagnostic testing, Hospitalization, surgery Yes ____ No ____
15. Mental Illness (depression, anxiety, bipolar, schizophrenia) Yes ____ No ____	**26. In the past 5 years, has anyone enrolling had symptoms or received treatment for any condition not on this form** Yes ____ No ____
16. Counseling (current or prior) Yes ____ No ____	

Additional Detail :

Please complete details for all questions with a yes answer in above sections

Question #	Name of Individual	Condition/Diagnosis	Date of Onset	Last Treatment	Treatment/Drug	Still Taking Y/N	Degree of Recovery

Employee please sign and date

Employee_____ Date _____