

# LARGE GROUP HEALTH QUESTIONNAIRE



**Physicians Plus**  
**INSURANCE CORPORATION**  
 PO Box 2078  
 Madison, WI 53701-2078

## A. EMPLOYEE INFORMATION

First Name	MI	Last Name	Social Security #	Date of Birth / /
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## B. HEALTH INFORMATION

1. Within the last 24 months have you or any dependents consulted, received treatment or had medication prescribed by a doctor, psychiatrist, psychologist or other practitioner or been diagnosed for: cancer; heart/circulatory disorder; high blood pressure; elevated cholesterol; mental or emotional disorder; muscular or systematic disease (such as arthritis; lupus); multiple sclerosis; respiratory disorder; diabetes; thyroid disorder; alcohol or drug use; liver; kidney or intestinal disorder (except genetic testing results); or enlarged lymph nodes, excluding AIDS/HIV?

YES (If yes, explain below)                       NO  
 Name(s) \_\_\_\_\_ Condition(s) \_\_\_\_\_

2. Are you or any eligible dependent (male or female) an expectant parent?  YES  NO      2a. Normal Pregnancy?  YES  NO  
 Name(s) \_\_\_\_\_ Due Date(s) \_\_\_\_\_

3. Have you or any dependent had a hospitalization, surgery or treatment in last 12 months?  YES (If yes, explain below)  NO  
 Name(s) \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Diagnosis given for hospitalization/surgery/treatment \_\_\_\_\_

4. Are you or any dependent scheduled for surgery or treatment in next 6 months?  YES (If yes, explain below)  NO  
 Name(s) \_\_\_\_\_ Date(s) \_\_\_\_\_  
 Reason for surgery/treatment \_\_\_\_\_

5. Are you or any dependents now disabled or unable to perform normal activities?  YES (If yes, explain below)  NO  
 Name(s) \_\_\_\_\_ Reason(s) \_\_\_\_\_

6. Please list any medications, including dosage, you or your dependents take and the condition for which they are prescribed.  
 \_\_\_\_\_

## C. SIGNATURE (THIS FORM MUST BE SIGNED)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and my eligible dependents, I hereby agree to the terms and conditions of enrollment.

Applicant Signature (required)	Date Signed	Spouse Signature (if applicable)	Date Signed
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I asked the applicant all the questions in this application and the answers are recorded as given to me (circle one).      Yes      No

Date / /	Writing Agent's Name (Print)	Writing Agent's Signature
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## FOR HEALTH PLAN USE ONLY

Group Number	Effective Date	Benefit Plan Level	Class	Department	Check Number	Check Amount
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