

HEALTH QUESTIONNAIRE

Individual and Large Group (2-25 enrolling)

A. APPLICANT INFORMATION - PLEASE TYPE OR PRINT; PRESS FIRMLY		
First Name	Last Name	Middle Initial
Social Security #	Phone Number ()	Date of Birth / /
B. HEALTH INFORMATION		
Please CIRCLE the condition if you are answering yes.		Please Circle One
1. Have you or your eligible dependents had or been treated during the past 5 years for:		
a. Diabetes or sugar, albumin or blood in the urine? Date diagnosed?		Yes No
b. High blood pressure, chest pain, heart murmur, heart attack, shortness of breath, angina or other heart/circulatory condition?		Yes No
c. Stroke, epilepsy, fainting, dizziness, headaches, encephalitis, dementia, Alzheimer's, or chronic headaches (migraines or sinus)?		Yes No
d. Tuberculosis, asthma, hay fever, emphysema, sleep apnea or any other lung/respiratory condition? If you answered YES to asthma, please indicate the date of your last attack: Have you ever received inpatient treatment?		Yes No Yes No
e. Ulcer, colitis, hepatitis, cirrhosis, crohn's or other stomach or liver condition?		Yes No
f. Varicose veins, varicose ulcers, phlebitis, or hernia of any kind?		Yes No
g. Kidney, bladder, prostate or other urinary condition?		Yes No
h. Rheumatoid arthritis, osteoarthritis, rheumatism or any other joint, muscle, back or bone condition including fibromyalgia?		Yes No
i. Cancer, tumor, cyst or abnormal growth? If you answered YES, please specify the type. Type _____ Date diagnosed _____ <input type="checkbox"/> Benign <input type="checkbox"/> Malignant (breast, ovarian, lung, etc.) Stage diagnosed (if Malignant) _____		Yes No
j. Any disorder of the eyes, ear, nose, or throat?		Yes No
k. Alcoholism, narcotic addiction - Have you or your eligible dependents joined any organization for alcoholism or drug abuse? Received inpatient treatment? If YES, please list specific diagnosis:		Yes No Yes No
l. Nervous or mental disorder including professional counseling, bipolar, depression, schizophrenia, suicide attempt, etc.? Received inpatient treatment? If YES, please list specific diagnosis and include inpatient dates:		Yes No Yes No
m. Multiple Sclerosis, cerebral palsy, muscular dystrophy or Down Syndrome?		Yes No
n. Thyroid condition? Graves' Disease?		Yes No
o. Parkinson's Disease?		Yes No
p. Eating disorders, including but not limited to bulimia and anorexia?		Yes No
q. Leukemia, lymphoma, sickle cell anemia, hemophilia?		Yes No
r. Lupus? Specify type: Systemic, discoid, etc.:		Yes No
2. Are you or any eligible dependent an expectant parent (male or female)? If YES, list the name of the dependent and approximate due date: If YES, is this considered a HIGH risk pregnancy? If YES, is there any previous cesarean, miscarriage or complications?		Yes No Yes No Yes No

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First Name **Last Name** **SS#**

3. Within the last five years, have you or any of your eligible dependents: a. Had any medical treatment, health or physical impairment, condition or congenital anomaly not mentioned above? b. In the last five years, have you or your dependents had a physical examination, electrocardiogram, X-ray, blood test, or diagnostic test, or seen a physician for any medical reason? (Excluding any AIDS antibody test or genetic test results.)	Yes	No
4. Have you or your eligible dependents ever been advised to have an organ transplant or kidney dialysis? If you answered Yes, please indicate date and type:	Yes	No
5. Have you or any of your eligible dependents scheduled, or been advised to schedule a hospitalization or surgery within the next 12 months?	Yes	No
6. Have you or any of your eligible dependents ever been disabled or unable to perform normal activities or filed a Workers Compensation claim?	Yes	No
7. Have medications been prescribed for you or your eligible dependents in the last 12 months for any reason?	Yes	No

8. Explanatory Comments: if you answered YES to any of the questions including those on page 1, please complete the section below. Please use a separate sheet of paper if you need additional room.

Question#	Person Treated	Illness/Condition Date of Diagnosis	Medication (including dosage)	Date and/or Type of Treatment Current Status

9. Please list the date of birth, height and weight for you and your eligible dependents:

Name	Date of Birth	Height	Weight

C. APPLICANT'S SIGNATURE

All statements and answers I have given are complete and true to the best of my knowledge and belief. I understand that any material mis-statement in this health questionnaire may result in denial of claims and/or rescission of coverage.

Applicant's signature	Date	Spouse's Signature (if applicable)	Date
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D. AGENT VERIFICATION - AGENT USE ONLY

Non Group Plan Coverage ONLY: I have asked the applicant all of the questions in this application and the answers are recorded as given to me -or- The information provided is true and correct to the best of my knowledge.

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

Group Number	Effective Date	Benefit Plan	Class	Dept.	Check Number	Check Amount

Other: