

Employee and Family Medical Questionnaire

Section 1:

Employee Information

Employer Name: _____

| Name of Family Members Applying for Coverage | Relationship | Date of Birth | Gender Male/Female | Height (feet, inches) | Weight (pounds) |
|--|--------------|---------------|--------------------|-----------------------|-----------------|
| | Employee | | | | |
| | Spouse | | | | |
| | Dependent | | | | |
| | Dependent | | | | |
| | Dependent | | | | |
| | Dependent | | | | |

Section 2:

Family Health History

Within the past two (2) years has a licensed member of the medical profession diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment from a licensed member of the medical profession? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

| | | |
|--|---|--|
| A. Heart/Circulatory <input type="checkbox"/> YES <input type="checkbox"/> NO | D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO | H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> A1. Anemia <input type="checkbox"/> A2. Angina <input type="checkbox"/> A3. Angioplasty/Stent <input type="checkbox"/> A4. Aneurysm <input type="checkbox"/> A5. Blood Clots <input type="checkbox"/> A6. Blood Disorder <input type="checkbox"/> A7. Bypass <input type="checkbox"/> A8. Cardiac Arrhythmia <input type="checkbox"/> A9. Chest Pain <input type="checkbox"/> A10. Congestive Heart Failure <input type="checkbox"/> A11. Coronary Heart Disease <input type="checkbox"/> A12. Heart Murmur <input type="checkbox"/> A13. Hemophilia <input type="checkbox"/> A14. High/Low Blood Pressure <input type="checkbox"/> A15. High Cholesterol <input type="checkbox"/> A16. Pacemaker (Reason Implanted:____) <input type="checkbox"/> A17. Palpitations <input type="checkbox"/> A18. Sickle Cell Anemia <input type="checkbox"/> A19. Stroke/TIA <input type="checkbox"/> A20. Varicose Veins <input type="checkbox"/> A21. Ventricular Tachycardia | <input type="checkbox"/> D1. Brain <input type="checkbox"/> D2. Breast <input type="checkbox"/> D3. Colon <input type="checkbox"/> D4. Cyst <input type="checkbox"/> D5. Hodgkin's Disease <input type="checkbox"/> D6. Leukemia <input type="checkbox"/> D7. Liver <input type="checkbox"/> D8. Lung <input type="checkbox"/> D9. Lymphoma <input type="checkbox"/> D10. Melanoma <input type="checkbox"/> D11. Ovarian <input type="checkbox"/> D12. Pituitary <input type="checkbox"/> D13. Prostate <input type="checkbox"/> D14. Stomach <input type="checkbox"/> D15. Testicular <input type="checkbox"/> D16. Thyroid <input type="checkbox"/> D18. Stage of Cancer if known____ <input type="checkbox"/> D19. Cancer Treatment: <input type="checkbox"/> Surgery <input type="checkbox"/> Chemo <input type="checkbox"/> Radiation | <input type="checkbox"/> H1. Bulging/Herniated Disk <input type="checkbox"/> H2. Carpal Tunnel Syndrome <input type="checkbox"/> H3. Fibromyalgia/CFS <input type="checkbox"/> H4. Fractures (Open or Closed) <input type="checkbox"/> H5. Gout <input type="checkbox"/> H6. Joint Replacement (Type:____) <input type="checkbox"/> H7. Knee <input type="checkbox"/> H8. Muscular Dystrophy <input type="checkbox"/> H9. Neck/Back <input type="checkbox"/> H10. Shoulder <input type="checkbox"/> H11. Spina Bifida <input type="checkbox"/> H12. Sprain/Strain |
| B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO | E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO | I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> B1. Acoustic Neuroma <input type="checkbox"/> B2. Cataracts <input type="checkbox"/> B3. Chronic Sinusitis <input type="checkbox"/> B4. Cleft Lip/Palate <input type="checkbox"/> B5. Detached Retina <input type="checkbox"/> B6. Deviated Septum <input type="checkbox"/> B7. Ear Infections <input type="checkbox"/> B8. Glaucoma <input type="checkbox"/> B9. Retinopathy | <input type="checkbox"/> E1. Alzheimer's Disease <input type="checkbox"/> E2. Cerebral Palsy <input type="checkbox"/> E3. Epilepsy <input type="checkbox"/> E4. Head Injury <input type="checkbox"/> E5. Migraines <input type="checkbox"/> E6. Multiple Sclerosis <input type="checkbox"/> E7. Neuritis <input type="checkbox"/> E8. Paralysis/Hemiplegia <input type="checkbox"/> E9. Parkinson's Disease <input type="checkbox"/> E10. Seizures/Convulsions Date Diagnosed?____ Date last seizure?____ | <input type="checkbox"/> I1. ADD/ADHD <input type="checkbox"/> I2. Alcoholism <input type="checkbox"/> I3. Anxiety <input type="checkbox"/> I4. Autism <input type="checkbox"/> I5. Bipolar <input type="checkbox"/> I6. Depression <input type="checkbox"/> I7. Drug Abuse <input type="checkbox"/> I8. Eating Disorder <input type="checkbox"/> I9. Schizophrenia <input type="checkbox"/> I10. Suicide Attempt |
| | | J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | | <input type="checkbox"/> J1. Diabetes controlled by: <input type="checkbox"/> a. Diet <input type="checkbox"/> b. Oral Medication <input type="checkbox"/> c. Insulin Date Diagnosed (____) <input type="checkbox"/> J2. Adrenal Glands |

| | | |
|--|---|---|
| C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO | F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> J3. Growth Hormones <input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism |
| <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. Lupus <input type="checkbox"/> C3. Psoriasis <input type="checkbox"/> C4. Scleroderma | <input type="checkbox"/> F1. Pending <input type="checkbox"/> F2. On Waiting List <input type="checkbox"/> F3. Completed Transplant <input type="checkbox"/> F4. Bone Marrow <input type="checkbox"/> F5. Stem Cell <input type="checkbox"/> F6. Organ (Type: _____) | K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO |
| | G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> K1. Breast Disorder <input type="checkbox"/> K2. Endometriosis <input type="checkbox"/> K3. Fibroids |
| | <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis | <input type="checkbox"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts |

| | | |
|---|--|--|
| L. Lung/Respiratory <input type="checkbox"/> YES <input type="checkbox"/> NO | M. Intestinal <input type="checkbox"/> YES <input type="checkbox"/> NO | N. Liver/Kidney/Urinary <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> L1. Allergies Injections <input type="checkbox"/> Yes <input type="checkbox"/> No How Often? _____ <input type="checkbox"/> L2. Asthma <input type="checkbox"/> L3. COPD (On Oxygen? _____) <input type="checkbox"/> L4. Cystic Fibrosis <input type="checkbox"/> L5. Emphysema <input type="checkbox"/> L6. Lung Disorder <input type="checkbox"/> L7. Pneumonia <input type="checkbox"/> L8. Sarcoidosis <input type="checkbox"/> L9. Sleep Apnea <input type="checkbox"/> L10. Tuberculosis <input type="checkbox"/> L11. Valley Fever | <input type="checkbox"/> M1. Acid Reflux/GERD <input type="checkbox"/> M2. Colitis/IBS <input type="checkbox"/> M3. Colon Disorder <input type="checkbox"/> M4. Crohn's Disease <input type="checkbox"/> M5. Diverticulitis/Diverticulum <input type="checkbox"/> M6. Gallbladder <input type="checkbox"/> M7. Gastric Bypass <input type="checkbox"/> M8. Hiatal Hernia/Reflux <input type="checkbox"/> M9. Pancreatitis <input type="checkbox"/> M10. Ulcer <input type="checkbox"/> M11. Ulcerative Colitis <input type="checkbox"/> Colectomy <input type="checkbox"/> Partial <input type="checkbox"/> Total <input type="checkbox"/> Ileostomy <input type="checkbox"/> Partial <input type="checkbox"/> Total | <input type="checkbox"/> N1. Bladder Disorder <input type="checkbox"/> N2. Cirrhosis <input type="checkbox"/> N3. Gaucher's Disease <input type="checkbox"/> N4. Hepatitis (Type: _____) <input type="checkbox"/> N5. Jaundice <input type="checkbox"/> N6. Kidney Disorder <input type="checkbox"/> N7. Kidney Stones (How Many? _____) <input type="checkbox"/> N8. Liver Disorder <input type="checkbox"/> N9. Polycystic Kidney <input type="checkbox"/> N10. Prostate <input type="checkbox"/> N11. Renal Failure <input type="checkbox"/> End Stage Renal Exhausted Part A Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No |

☐ **YES** ☐ **NO** In addition to the information provided above, have you or anyone applying for coverage sought medical advice or treatment from a licensed member of the medical profession for any condition not previously mentioned in this form, including a Workers Compensation injury or illness? If yes, please provide details on an attached sheet.

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

| Question Number | Name | Diagnosis/Treatment | Date of Onset | Date Treatment Ended | Medications Prescribed | Dosage | Still Taking Medication |
|-----------------|------|---------------------|---------------|----------------------|------------------------|--------|---|
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| | | | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |

If you are providing additional sheets, check here ☐ and insert the sheets before sealing this enrollment form.

Section 3

Please answer the following questions for yourself and for anyone in your family applying for coverage:

1. ☐ YES ☐ NO Is anyone currently pregnant or an expectant parent?

Due date: _____

- ☐ Yes ☐ No a. Has the pregnancy been confirmed by a physician or practitioner?
☐ Yes ☐ No b. Pregnancy complications?
☐ Yes ☐ No c. Multiple births expected?
☐ Yes ☐ No d. Planned C-Section?

2. ☐ YES ☐ NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?

3. ☐ YES ☐ NO Does anyone currently use tobacco products? If Yes, check applicable boxes:

- ☐ Employee ☐ Spouse
☐ cigarettes ☐ pipes ☐ cigars ☐ chewing tobacco

4. ☐ YES ☐ NO Has any person to be covered currently receiving, or in the past 12 months been advised by a licensed member of the medical profession to have any of the following?

- ☐ abnormal test or physical results
☐ health condition, illness or injury that may require treatment or surgery
☐ tests advised
☐ treatment advised
☐ surgery advised
☐ unexplained weight gain/loss
☐ unexplained fatigue

5. ☐ YES ☐ NO Does any person to be covered currently have any pending test results requested by a licensed member of the medical profession?

6. ☐ YES ☐ NO Has anyone applying for coverage had medical claims in excess of \$7,500 in the past 2 years?

7. ☐ YES ☐ NO Has any one applying for coverage, ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

8. ☐ YES ☐ NO In addition to the information provided above, are you taking any other prescription medications? If yes, please list the medication on an attached sheet.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

I authorize any health care provider, pharmacy benefit manager, other insurer or reinsurer, hospital, clinic or other medical facility, health care clearinghouse, and any of their affiliates, representatives or business associates, to disclose my information to (name of insurer). I understand the purpose of the disclosure and use of my information is to allow (name of insurer) to make decisions regarding underwriting and premium risk rating.

Employee Signature: _____ Date Signed: _____