

FLORIDA HEALTH CARE PLANS EMPLOYEE QUESTIONNAIRE

Health Questionnaire for Groups Enrolling 9 or less Employees

Health History for Individuals and Their Dependents. *The following information is confidential and will not be seen by or given to your employer.* ALL of the questions must be answered by you or your application will be returned. Incomplete applications may delay the effective date of your coverage.

Employee Name _____ SSN _____ Group Name _____	
Has anyone on this application consulted with or been examined or treated by any health care professional during the last 10 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below. Please note that, if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective.	
1 Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Lymphoma <input type="checkbox"/> Cervical <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Prostate Stage _____ <input type="checkbox"/> Other _____
2 Heart/Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Heart Attack <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Chest Pain <input type="checkbox"/> Anemia <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Other _____
3 Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____) <input type="checkbox"/> Multiples (# __) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Fibroids _____ <input type="checkbox"/> Other _____
4 Intestinal/Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Other _____
5 Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Tumor <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Paralysis _____ <input type="checkbox"/> Seizures/Epilepsy _____ <input type="checkbox"/> Other _____
6 Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS _____ <input type="checkbox"/> Rheumatoid Arthritis _____ <input type="checkbox"/> Psoriasis _____ <input type="checkbox"/> Lupus _____ <input type="checkbox"/> Immuno Deficiency _____ <input type="checkbox"/> Other _____
7 Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> COPD <input type="checkbox"/> Other _____
8 Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Retinopathy <input type="checkbox"/> Other _____
9 Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Chronic Kidney Disease (CKD) <input type="checkbox"/> Other _____
10 Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/CFS <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Chronic Lower Back Pain <input type="checkbox"/> Other _____
11 Behavioral Health <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar/Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpat ETOH/Drug <input type="checkbox"/> Inpat MH Hosp <input type="checkbox"/> Autism _____ <input type="checkbox"/> Eating Disorder _____ <input type="checkbox"/> Other _____
12 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Transplant Complications <input type="checkbox"/> Discussed Possible Future Transplant Year _____ <input type="checkbox"/> Stem Cell _____ <input type="checkbox"/> Other _____
13 Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications Please List Meds _____ <input type="checkbox"/> Medications Taken Within The Past Year Please List Meds _____
14 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abnormal Test Or Physical Results <input type="checkbox"/> Condition Not Mentioned Above <input type="checkbox"/> Treatment Or Surgery Discussed Or Advised <input type="checkbox"/> Pending Test Results <input type="checkbox"/> Inpat Hosp/Surg in Past Yr. <input type="checkbox"/> Pending w/c claim <input type="checkbox"/> Tests Advised or Recommended <input type="checkbox"/> Refer to Specialist <input type="checkbox"/> Disability
15 Physical deformity, defect or congenital problem?	Please List _____
16 Alcohol Usage <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Advised to seek treatment? _____
17 Tobacco Usage <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco products, including cigarette, pipe, cigar, or chewing tobacco? If Yes, check applicable boxes: Employee <input type="checkbox"/> Spouse <input type="checkbox"/>
18 Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, list date of diagnosis: ____/____/____ (month/day/year) Insulin dependent Non-insulin dependent
19 HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Has any person listed on this enrollment form been 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?

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IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE (EXCEPT LAST QUESTION), YOU MUST COMPLETE THE FOLLOWING SECTION TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

Section II. Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section I. In addition, please give details below of last doctor visit and/or physical examination for ALL family members listed regardless of the date or reason.

Question #	Name of Individual	Condition/Diagnosis Date	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication	
							Yes	No
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>
							<input type="checkbox"/>	<input type="checkbox"/>

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

I understand the purpose of the disclosure and use of my information is to allow FHCP and Affiliates to make decisions regarding underwriting and premium risk rating. I understand this authorization is voluntary and I may refuse to sign the authorization. My refusal may, however, affect my ability to enroll in the health plan or receive benefits, if permitted by law. I understand I may revoke this authorization at any time by notifying my FHCP and Affiliates representative in writing, except to the extent that action has already been taken in reliance on this authorization. As required by HIPAA, FHCP and Affiliates also request that I acknowledge the following, which I do: I understand that information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this Florida Small Group Business Employee Enrollment/Change Form.

Misrepresentation: 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.

Employee Name (Print)_____

Group Name:_____

X_____
Employee Signature

Date:_____