

Employee Name _____

Health Questionnaire

Health history of you and your family (include information about family members you wish to cover) – Has any person listed on this application ever consulted for, sought treatment, had treatment recommended, received treatment, been surgically treated or been hospitalized for any of the following conditions: *(Please answer Yes or No. Incomplete applications will be returned to you for completion which may delay the effective date of your coverage.)*

- 1) Has any person listed on this application been hospitalized for any medical condition, chemical or substance abuse problem in the past two years? Yes No
- 2) Is any female to be covered under this policy currently pregnant? If currently pregnant have you had complications with current or past pregnancies? Yes No
Please provide due date and details below.

3) Have you or your enrolling family members ever been treated for:	Still under Treatment?	Date ended
• Any Cancer (including Hodgkin's or Leukemia) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Hemophilia Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Multiple Sclerosis/ALS (Lou Gehrig's) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Rheumatoid Arthritis or other connective tissue disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Hepatitis Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Any Immune Deficiency disorder HIV/AIDS or Aids Related Complex (ARC) Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Lyme Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Chronic Back or Disc problems Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
• Coronary Artery Disease/Angio/CABG or stents Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

If you answered yes to question 1, 2, or 3 or have any medical conditions not listed above please provide full details of treatment.

- 4) Please list any **prescription drugs, over the counter (OTC) drugs, and/or injectible medications** you or your enrolling family members are regularly taking or supposed to be taking.

Employee/ Dependent Name	Diagnosis	Drug Name	OTC Yes/No	Dosage	Frequency of Dose

Please use additional paper if necessary

Other Medical Coverage for ALL Enrolling Employees and Dependents *(All questions must be answered)*

- A. Do any persons on this application intend to continue other group coverage if this application is accepted? Yes No
If yes, name of person: _____ Insurance Company: _____
- B. Does any person applying for coverage have health insurance coverage: Yes No
If yes, applicant/family member(s) name: _____ Type of continuous coverage: Group Individual Other
Insurance Company: _____ Date Coverage Began: _____ Date Coverage Ended: _____
- C. Is any person applying for coverage eligible for Medicare? Yes No

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.