



INDIVIDUAL HEALTH QUESTIONNAIRE

CHECK ONE

- Initial Enrollee
- Late Enrollee(s)
- Existing Member

FOR FIRMS WITH 10 OR MORE ENROLLING:

All owner/employees referred to on page 31 with a "Yes" answer should complete this form for themselves and/or their dependents.

FOR FIRMS WITH 6-9 OWNERS/EMPLOYEES ENROLLING:

each Employee should complete this form for themselves and/or their dependents.

PLEASE PROVIDE COMPLETE INFORMATION TO ASSURE TIMELY ADMINISTRATION OF CLAIMS

Information provided will not cause medical plan enrollment denial

(If you and/or your eligible dependents have chosen to decline health coverage you are not required to complete this questionnaire)

1. EMPLOYEE INFORMATION

Employee Name	Gender	Height	Weight	Social Security Number	DOB	Employer Name
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2. HEALTH QUESTIONNAIRE

Please answer YES or NO to each of the following questions for yourself and each of your dependents. *For each YES answer, Please explain and provide complete details. HAVE YOU OR ANY OF YOUR DEPENDENTS:*

Been diagnosed with, treated for, or had treatment recommended within the last five (5) years for any of the following:

	Yes	No		Yes	No	
a. Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Other Conditions / Information: m. Are you or any dependents now pregnant? If yes, First pregnancy? _____ Complications with this or any prior pregnancy? _____ n. Any other medical condition that has not been disclosed above? If so, describe in detail below. o. Have you or your dependents smoked in the last 2 years? If yes, date stopped: _____ p. Are you or any of your dependents taking any medication (except antibiotics or contraceptives) that require a prescription by a Physician? q. Have you or your dependents gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____ r. Are you actively at work at least 20 hours per week? s. Have you or your dependents been admitted to a hospital or had surgery in the past five (5) years? t. Have you or your dependents been told that it may be necessary to be admitted to the hospital or have surgery in the future?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer, tumor or other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
d. Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
e. Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
f. AIDS, AIDS-related complex or other immune deficiency disorders, infections or chronic infection problems?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
g. Alcohol or substance abuse, metal/nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
h. Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
i. Diabetes, cystic fibrosis, albumin or sugar in the urine or other endocrine problems?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
j. Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
k. Paralysis, epilepsy, M.S. or other neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>
l. Bleeding or blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	

3. DETAILED EXPLANATIONS

Item No.	Name of Person Treated	Height/Weight	Diagnosis/Condition	Type of Treatment	Medications/Dosage	Treatment Provider	<input type="checkbox"/> Still under treatment Treatment dates
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)

4. Signature

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that the Health Statement is part of my request for health coverage. Information provided will not cause medical plan enrollment denial. However, I understand that if I have misrepresented or omitted any material fact, my coverage may be cancelled or the contract rescinded.

Employee Signature _____

Date _____