

Employee and Family Health Information

ENROLLMENT

Reason for Enrollment (mark all that apply)

WAIVER

- New Group Divorce* Court Order*
 Open Enrollment Loss of Coverage* Adoption*
 New Hire Marriage* Newborn*

*Date of Event _____

A. Employee Information

Last Name _____ First Name _____ M.I. _____
 SSN _____ Status Single Legally Married Separated Divorced
 Street Address _____ Unit # _____ Home Ph# _____
 City _____ State _____ Zip _____
 Company Name _____ Work Ph# _____ # Hours /Wk _____
 Job Title _____ *Full-Time hire date _____

* Full-Time Hire Date is the first day physically at work, working 30 hours or more per week consistently. Providing an incorrect hire date could result in coverage being delayed or denied

B. EMPLOYEE AND DEPENDENT INFORMATION (List yourself and eligible dependent(s) to be covered below)

Relationship	Name <small>(FIRST, MIDDLE (initial), LAST)</small>	Social Security #	Gender M/F	Height <small>Feet, Inches</small>	Weight <small>Pounds</small>	Other Ins	Name of Other Ins Carrier
EMPLOYEE			M/F			Y/N	
SPOUSE			M/F			Y/N	
DEPENDENT			M/F			Y/N	
DEPENDENT			M/F			Y/N	
DEPENDENT			M/F			Y/N	
DEPENDENT			M/F			Y/N	
DEPENDENT			M/F			Y/N	

C. PRIOR COVERAGE INFORMATION

If you have had health insurance coverage within the last 63 days, your Pre-existing Condition Waiting Period Limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior healthcare provider. To determine if this applies to you, enclose a copy of the Certificate of Creditable Coverage for each member to be covered and provide the information requested below. Failure to provide this information could result in claims being delayed or denied. (Note: A photocopy of your ID Card from your current/previous carrier is not sufficient.)

Policyholder's Name _____ Name of Carrier _____
 Policy _____ Date Coverage Began _____ Date _____

Submission of prior coverage information does not automatically waive the Pre-existing Condition Waiting Period limitation. However, failure to provide prior coverage information will result in limited or excluded benefits for a 12-month period (18 months for late enrollees).

E. EMPLOYEE SIGNATURE

Employee Signature _____ Date _____

Employee and Family Medical Questionnaire

Section 1: Employer/Employee Information

Employer Name: _____

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

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? 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 <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 <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"/> A22. Other ()		D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO <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"/> D17. Other () <input type="checkbox"/> D18. Stage of Cancer if known		H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO <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 <input type="checkbox"/> H13. Other ()	
B. Eyes/Ears/Nose/Throat <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"/> B10. Other ()		E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO <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 <input type="checkbox"/> E11. Other ()		I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO <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 <input type="checkbox"/> I11. Other ()	
C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. AIDS <input type="checkbox"/> C3. HIV+ <input type="checkbox"/> C4. Immuno Deficiency <input type="checkbox"/> C5. Lupus <input type="checkbox"/> C6. Psoriasis <input type="checkbox"/> C7. Scleroderma <input type="checkbox"/> C8. Other ()		F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO <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:)		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 <input type="checkbox"/> d. Other () <input type="checkbox"/> J2. Adrenal Glands <input type="checkbox"/> J3. Growth Hormones <input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism <input type="checkbox"/> J5. Other ()	
		G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis <input type="checkbox"/> G4. Other ()		K. Reproductive <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"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts <input type="checkbox"/> K6. Other ()	

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		<input type="checkbox"/> M1. Acid Reflux/GERD		<input type="checkbox"/> N1. Bladder Disorder	
<input type="checkbox"/> L2. Asthma		<input type="checkbox"/> M2. Colitis/IBS		<input type="checkbox"/> N2. Cirrhosis	
<input type="checkbox"/> L3. COPD (On Oxygen? _____)		<input type="checkbox"/> M3. Colon Disorder		<input type="checkbox"/> N3. Gaucher's Disease	
<input type="checkbox"/> L4. Cystic Fibrosis		<input type="checkbox"/> M4. Crohn's Disease		<input type="checkbox"/> N4. Hepatitis (Type: _____)	
<input type="checkbox"/> L5. Emphysema		<input type="checkbox"/> M5. Diverticulitis/Diverticulum		<input type="checkbox"/> N5. Jaundice	
<input type="checkbox"/> L6. Lung Disorder		<input type="checkbox"/> M6. Gallbladder		<input type="checkbox"/> N6. Kidney Disorder	
<input type="checkbox"/> L7. Pneumonia		<input type="checkbox"/> M7. Gastric Bypass		<input type="checkbox"/> N7. Kidney Stones	
<input type="checkbox"/> L8. Sarcoidosis		<input type="checkbox"/> M8. Hiatal Hernia/Reflux		<input type="checkbox"/> N8. Liver Disorder	
<input type="checkbox"/> L9. Sleep Apnea		<input type="checkbox"/> M9. Pancreatitis		<input type="checkbox"/> N9. Polycystic Kidney	
<input type="checkbox"/> L10. Tuberculosis		<input type="checkbox"/> M10. Ulcer		<input type="checkbox"/> N10. Prostate	
<input type="checkbox"/> L11. Valley Fever		<input type="checkbox"/> M11. Ulcerative Colitis		<input type="checkbox"/> N11. Renal Failure	
<input type="checkbox"/> L12. Other (_____)		<input type="checkbox"/> M12. Other (_____)		<input type="checkbox"/> N12. Other (_____)	

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

- 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 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?
- YES NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?
- YES NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?
 abnormal test or physical results pending test results
 health condition, illness or injury that may require treatment or surgery
 tests, treatment or surgery advised unexplained weight gain/loss or fatigue
 Worker's Compensation injury or illness condition not mentioned above in Section 2

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	Diagnosis Date	Treatment Status

Section 3: Family Medications

YES NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

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.

Employee Signature: _____

Date Signed: _____

