

Health Questionnaire

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 and your dependents or the application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the application seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
4. Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system? If epileptic, date of last seizure: ___/___/___ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered had or has been told that they have an immune disorder, AIDS or AIDS related complex?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any person been diagnosed with diabetes? If yes, list date of diagnosis: ___/___/___ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
Insulin dependent? _____ Non-insulin dependent? _____		
12. a. Is any female to be covered currently pregnant? If yes, list due date: ___/___/___ (month/day/year)	<input type="checkbox"/>	<input type="checkbox"/>
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
d. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
13. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has any applicant had any medical condition or symptom not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, YOU MUST COMPLETE THE FOLLOWING.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked on Page 2. **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. (Insert additional sheets if necessary.)

Ques. # [] Name of Applicant: _____ **Name of Illness/Condition:** _____

Date of Onset: Month ___ Year ___ Date Treatment Ended: Month ___ Year ___ Still under Treatment: Yes No

Medication: _____ Date Prescribed: Month ___ Year ___ Dosage: _____

Treatment Given: _____

Ques. # [] Name of Applicant: _____ **Name of Illness/Condition:** _____

Date of Onset: Month ___ Year ___ Date Treatment Ended: Month ___ Year ___ Still under Treatment: Yes No

Medication: _____ Date Prescribed: Month ___ Year ___ Dosage: _____

Treatment Given: _____

Ques. # [] Name of Applicant: _____ **Name of Illness/Condition:** _____

Date of Onset: Month ___ Year ___ Date Treatment Ended: Month ___ Year ___ Still under Treatment: Yes No

Medication: _____ Date Prescribed: Month ___ Year ___ Dosage: _____

Treatment Given: _____

Ques. # [] Name of Applicant: _____ **Name of Illness/Condition:** _____

Date of Onset: Month ___ Year ___ Date Treatment Ended: Month ___ Year ___ Still under Treatment: Yes No

Medication: _____ Date Prescribed: Month ___ Year ___ Dosage: _____

Treatment Given: _____

Age _____ **Sex** _____ **Height** _____ **Weight** _____