EMPLOYEE HEALTH QUESTIONNAIRE

I am applying for the following coverage:
☐ Employee only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

EMPLOYEE/DEPENDENT INFORMATION

LAST NAME FIRST NAME	SEX	HEIGHT	WEIGHT	DOB	RELATIONSHIP	F/T Student

GENERAL HEALTH QUESTIONS:

Please put an "X" next to any question that applies to you / & any dependent ELECTING coverage

A) ____ yes ____ no Are you or any enrolling dependents receiving treatment or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and explain.

B) ____ yes ____ no Are you or any enrolling dependents currently disabled, confined to a hospital, medical facility or the home?

C) ____ yes ____ no Have you or any applying dependent incurred medical expenses over $10,000 in the past 12 months?

D) ____ yes ____ no Are you or your enrolling dependents currently taking or have been taking prescribed medications within the past 12 months?

E) ____ yes ____ no Within the past five (5) years, has any person to be insured had any symptoms, diagnosis, consultation, treatment or take any medication or received counseling for:

E1) ____ yes ____ no abnormal heart beat/palpitations, blood disorder/hemophilia/hypertension, chest pain, heart disease/murmur/heart attack or Coronary Artery Disease, Lymphadenopathy/immune disorder, Stroke, Vascular Disorder
High Blood Pressure (current readings) _____/_____), (_____/_____)
High Cholesterol (current reading _____)
High Triglycerides (current reading_____)

E2) ____ yes ____ no Cancer, tumors/cysts/polyps/growths

E3) ____ yes ____ no Diabetes/pancreatic disorders, thyroid or goiter

E4) ____ yes ____ no Colitis, hepatic, spastic colon, polyps, digestive disorders/reflux, gallbladder disorder, hernia, Ulcerative colitis/crohn's/regional ileitis, ulcers

E5) ____ yes ____ no Abnormal Pap smear, bladder disorder, breast disorder, infertility testing/treatment, kidney Disorder, menstrual disorder, prostate/rectal disorder, reproductive organs Disorder/endometriosis, sexually transmitted diseases.

____ yes ____ no Currently pregnant (expected due date____ _____)

E6) ____ yes ____ no Anorexia/Bulimia, epilepsy and or seizure, headaches/migraines, mental, nervous, emotional disorder/anxiety/depression/attention deficit disorder, mental retardation/down's syndrome, muscular dystrophy/cerebral palsy, neurological disease, paralysis, sleep disorder.

E7) ____ yes ____ no abnormal test results, alcoholism/alcohol abuse, drug addiction, ear/throat disorders, eye disorders, acquired immune deficiency syndrome (AIDS), transplants.

E8) ____ yes ____ no Allergies, asthma/respiratory disorder, cystic fibrosis, emphysema/lung disorder, sinus disorder, tuberculosis.

E9) ____ yes ____ no Arthritis, back/muscle/joint disorder, bone disease/deformity, congenital disorder Fractures/dislocations, lupus/systemic or discoid, rheumatism, skin disorder, spinal disorder/back/neck strain

Please provide COMPLETE details to any questions marked "YES" in the boxes below. If additional space is needed please attach a separate page.

QUES. #	PERSON'S NAME	CONDITIONS & ANY MEDICATION(s) CURRENTLY TAKNG FOR CONDITION	DATE OF ONSET Mo/Yr	RECOVERY DATE Mo/Yr	NAME & ADDRESS OF DR & HOSPITAL