

# Health Questionnaire

*To be completed by employee*

**PLEASE PROVIDE COMPLETE INFORMATION TO ASSURE TIMELY ADMINISTRATION OF CLAIMS**  
**INFORMATION PROVIDED WILL NOT CAUSE MEDICAL PLAN ENROLLMENT DENIAL**  
*(IF YOU AND YOUR ELIGIBLE DEPENDENTS HAVE CHOSEN TO WAIVE HEALTH COVERAGE YOU ARE NOT REQUIRED TO COMPLETE THIS QUESTIONNAIRE)*

**CHECK ONE**  
 Initial Enrollee  
 Late Enrollee(s)  
 Existing Member

## 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:**

- |   |                              |                                       |     |    |
|---|------------------------------|---------------------------------------|-----|----|
| 1. Been admitted to a hospital or had surgery in the past five (5) years?   | <input type="checkbox"/> YES | <input type="checkbox"/> NO           |     |    |
| 2. Been told that it may be necessary for you to be admitted to the hospital or have surgery in the future?                                   | <input type="checkbox"/> YES | <input type="checkbox"/> NO           |     |    |
| 3. Been diagnosed with, treated for or had treatment recommended within the last five (5) years for any of the following:                     |                              |                                       | 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"/>              |     |    |
| b. Hypertension?  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| c. Cancer, Tumor or other malignancy?   | <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"/>              |     |    |
| e. Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?   | <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"/>              |     |    |
| g. Alcohol or substance abuse, mental/nervous disorders?  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| h. Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?  | <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"/>              |     |    |
| j. Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| k. Paralysis, epilepsy, M.S. or other neuromuscular disorder?   | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| l. Bleeding or blood disorders?   | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| <b>Other Conditions/Information</b>   |                              |                                       |     |    |
| m. Are you or any dependents now pregnant?  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| n. Any other medical condition that has not been disclosed above? If so, describe in detail below?  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| o. Have you or your dependents smoked in the last 2 years?<br>If yes, date stopped - _____  | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| p. Are you or any of your dependents taking any medication (except antibiotics or contraceptives) that require a prescription by a physician? | <input type="checkbox"/>     | <input type="checkbox"/>              |     |    |
| q. Have you or your dependents gained or lost more than 20 pounds in the last year?   | <input type="checkbox"/> YES | <input type="checkbox"/> Gained _____ |     |    |
|   | <input type="checkbox"/> NO  | <input type="checkbox"/> Lost _____   |     |    |
| r. Are you actively at work at least 20 hours per week?   | <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 \_\_\_\_\_