

GROUP NAME: _____

EMPLOYEE NAME:	PHONE NUMBER:	SSN:
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FAMILY INFORMATION: List <u>All Enrolling</u> Individuals							
Name	Relationship	Birthdate	Sex	Smoker	Height	Weight	F/T Student?
	SELF						<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

MEDICAL INFORMATION

1. Have you, your spouse or any listed dependent been treated for, diagnosed as having, been recommended for future surgery, diagnostic testing or medical treatment for any of the following conditions within the past 5 years?

IF YES, CHECK THE BOX BESIDE THE CONDITION AND EXPLAIN IN THE SECTION AT THE BOTTOM OF THE PAGE

<input type="checkbox"/> Abnormal Pap Smears	<input type="checkbox"/> Congenital Disease	<input type="checkbox"/> Graves Disease
<input type="checkbox"/> AIDS, ARC or HIV	<input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Allergies	<input type="checkbox"/> Coronary Artery Disease/ Angina	<input type="checkbox"/> Heart Bypass
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Angioplasty	Last 3 blood sugars & Dates:	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Arthritis	1. _____	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Asthma	2. _____	<input type="checkbox"/> Joint Replacement
<input type="checkbox"/> Chronic Bronchitis	3. _____	<input type="checkbox"/> Kidney Failure
<input type="checkbox"/> Cancer: type _____	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Carpel Tunnel Syndrome	<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Lou Gehrip's Disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Mental/ Psychological Health Disorders
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Migraines
<input type="checkbox"/> Chemical Dependency	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Ovarian Cyst
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Fibomyalgia	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Gallbladder Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Colitis	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Thyroid Disorder
	<input type="checkbox"/> Gout	<input type="checkbox"/> Transplant

2. Have you, your spouse or any listed dependent been treated for or told that you have any other condition/ disorder/ disease not listed above? Yes No
3. Are you, your spouse or any listed dependent currently pregnant or an expectant parent? Yes No
4. Are you, your spouse or any listed dependent currently taking any prescription medications? Yes No
5. Do you, your spouse or any listed dependent have a condition covered by Workers' Compensation? Yes No
If yes, please provide the Workers' Compensation Case number: # _____

EXPLANATION TO ALL QUESTIONS ANSWERED YES

Individual's Name	Condition	Treatment Dates	Diagnosis/ Treatment/ Prognosis/ Medication/ Dosage/ Reason

Attach a separate sheet in this format if more space is required

Employee Signature: _____ Date: _____

By signing I attest the information is complete and correct to the best of my knowledge. I also acknowledge this is not an application for insurance coverage, and the information provided will be used to provide an illustration for potential coverage and is not binding.