

Employee Enrollment Information / Medical Questionnaire

Employee Last Name	First Name, MI	Gender	Social Security #	Date of Birth
Street Address	City	State	Zip	Phone Number

Medical Coverage Selected: Single Single + Spouse Single + Child(ren) Family

Covered Dependent Name	Gender	Date of Birth	Social Security #	FT Student?

Does Any Family Member have other medical insurance or Medicare? Yes No

If yes, who has other coverage and what is the Insurance Company Name?

Medical History Information:

Has any covered person received consultation or treatment for any of the following conditions in the past 2 years?

- | | | |
|---|--|---|
| Yes No
<input type="checkbox"/> <input type="checkbox"/> Cancer/Neoplasm/Lymphoma
<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> CVA / Stroke
<input type="checkbox"/> <input type="checkbox"/> Injuries
<input type="checkbox"/> <input type="checkbox"/> Hypertension
<input type="checkbox"/> <input type="checkbox"/> Congenital Disorder
<input type="checkbox"/> <input type="checkbox"/> Sickle Cell | Yes No
<input type="checkbox"/> <input type="checkbox"/> Leukemia
<input type="checkbox"/> <input type="checkbox"/> Connective Tissue Disorders
<input type="checkbox"/> <input type="checkbox"/> Heart or Blood Disorder
<input type="checkbox"/> <input type="checkbox"/> Back/Joint Disorder
<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy / Cystic Fibrosis
<input type="checkbox"/> <input type="checkbox"/> Hyper or Hypothyroid
<input type="checkbox"/> <input type="checkbox"/> Pregnancy Complications
<input type="checkbox"/> <input type="checkbox"/> Stomach/Intestinal Disorders | Yes No
<input type="checkbox"/> <input type="checkbox"/> Lung Disease/Disorder
<input type="checkbox"/> <input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> <input type="checkbox"/> Myasthenia Gravis
<input type="checkbox"/> <input type="checkbox"/> Neurological Disorder
<input type="checkbox"/> <input type="checkbox"/> Any Pending Surgery
<input type="checkbox"/> <input type="checkbox"/> Or Condition > \$10k in Claims
<input type="checkbox"/> <input type="checkbox"/> Liver Disorders
<input type="checkbox"/> <input type="checkbox"/> Renal Disorders
<input type="checkbox"/> <input type="checkbox"/> Chronic Psychiatric Disorders |
|---|--|---|

Explain all Conditions Checked above in the table below.

Patient Name	Current Diagnosis	Date Diagnosed (Mo/Yr)	Type of Ongoing Care	Prescription Medications?

If you require more room, please use the back of this form.

I certify that the information contained in this enrollment information / medical questionnaire form is true accurate to the best of my knowledge. I understand that intentional misstatements on this form may constitute fraud and will result in the rescission of coverage. This information is not being utilized to determine if you or any dependents are eligible to enroll in coverage. It is being utilized to determine benefit availability according to the plan sponsored by your Employer.

Signature: _____

Date: _____