For Groups of 10-25 Employees*

Individual Health Questionnaire

Employee Information

Group Name:				YES	NO		YES NO
Employee's Name:	Age:	Enroll:	○	○	If no, other coverage?	○	○
Spouse's Name:	Age:	Enroll:	○	○	If no, other coverage?	○	○
Number of Dependent Children:	Age(s):	Enroll:	○	○	If no, other coverage?	○	○
Employee's Height: _____ ft. _____in.		Spouse's Height: _____ ft. _____in.					
Employee's Weight: _____now; _____ one year ago		Spouse's Weight: _____now; _____ one year ago					

Health Information

Are you or your dependents afflicted or diagnosed with a major disease or illness? (If yes, explain below)	YES ○	NO ○
Are you or your dependents anticipating any medical or surgical treatment in the next year? (If yes, explain below)	YES ○	NO ○
Do you or your dependents currently take any prescription medication? (If yes, explain below)	YES ○	NO ○
Have you or your dependents used any type of tobacco product within the past 5 years? (If yes, explain below)	YES ○	NO ○

Health Information (Please use the back of the form if needed)

Please include: Blood Disorders, Cancer (include type), Congenital Disorders, Cystic Fibrosis, Diabetes, Pregnancy (anticipated complications), Liver Disease, Heart Disease, Transplants (include type), Multiple Sclerosis, or other major illnesses.

Individual Name	Date (First / Last)		Diagnosis	Prognosis	Expense

Prescription Medication Information (Please use the back of the form if needed)

Individual Name	Date (First / Last)		Name and Dosage of Medication	Reason for Medication	Expense

Signature

I certify that the information stated above is true and correct and acknowledge that any coverage issued by the Plan will be issued in reliance thereon.

Employee Signature	Date

* Groups of 26 or more employees can complete this form for possible preferred pricing