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 ○

Please list any of the following: Blood Disorders, Cancer (include type), Congenital Disorders, COPD, Cystic Fibrosis, Diabetes, Digestive System (including Crohn's and Colitis), Heart Disease, Kidney Disease, Liver Disease, Lung Conditions, Pregnancy (including any anticipated complications), Transplants (include type), Multiple Sclerosis, Rheumatoid Arthritis or other major illnesses.

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)

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