

EMPLOYEE HEALTH BENEFITS QUESTIONNAIRE FOR GROUP PLANS

Company: _____ Today's Date: _____

Name: _____ City: _____ St: _____ Zip: _____

I chose NOT to elect health insurance coverage because I am covered under:

Spouse's plan Parent's plan Other plan (specify) _____

I want to cover the following family members under this plan:

Myself only Myself & Spouse Myself & Child(ren) My Family

Information about you:

Male Female Birth date: _____ Height (ft-in): _____ Weight: _____

Annual Salary: _____ Job Title: _____

The following questions should be answered to the best of your knowledge. All questions must be answered for you and family members you plan to insure. If you answer yes to any question, please provide as much detail as you have available in area below.

	YES	NO
Have you or any dependents been diagnosed and/or treated during the past 5 years for any of the following: heart disease, high blood pressure, stroke, diabetes, seizures, kidney diseases, back disorders, chronic lung disorders, cancer, tumors, congenital disorders, alcohol or drug abuse, mental or nervous conditions, muscular dystrophy, multiple sclerosis, AIDS, ARC, HIV Infection?	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any dependents had medical claims in excess of \$5,000 during the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or any dependents currently pregnant? Please include persons not currently on your plan.	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any dependents been hospitalized or had any surgical operations in the past 2 years?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been absent from work for two consecutive weeks due to illness or injury during the past 2 years? If injury, please state if it was a Workers Comp claim.	<input type="checkbox"/>	<input type="checkbox"/>
Have you or any dependents been advised to undergo medical treatment, surgery, diagnostic testing or hospitalization within the next 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or any dependents currently taking prescriptions? If so, what?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently receiving disability benefits?	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to any of the above questions please provide details below.

Signature of authorized person completing this form

Print name

