

MEDICAL DISCLOSURE QUESTIONNAIRE

The information in this form is extremely important to adequately underwrite your employers Medical Stop Loss Coverage. We are committed to protecting your privacy and the medical information you provide is used solely for the underwriting of the groups reinsurance coverage.

General Information				
Employer Name:			Employer City, State:	
Employee Name:			Waiver of Healthcare Coverage:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee Address, City, State, Zip Code:				
Employment Status:	<input type="checkbox"/> Active	<input type="checkbox"/> Disabled	<input type="checkbox"/> Cobra	Cobra start date: <input type="text"/> Cobra end date: <input type="text"/>

Employee and Dependent Information

Complete for Employee and all individuals to be covered:

Name	Relation to Employee	DOB	Sex	Height	Weight	Tobacco Use	Disabled	Other Insurance
			<input type="checkbox"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<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"/> F <input type="checkbox"/> M			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Other Insurance or Medicare

If you indicated that you and/or your dependent(s) will have other insurance coverage when this policy begins, please complete the following:

Other Insurance Company:		Name of Policy Holder:	
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No	Medicare Part A Effective Date:	Medicare Part B Effective Date:	
Qualification for Medicare:	<input type="checkbox"/> Age	<input type="checkbox"/> Disability	<input type="checkbox"/> ESRD <input type="checkbox"/> Lou Gehrig's Disease

Medical Information

Has any applicant been diagnosed with, treated for, or had any medical advice, or have symptoms that may indicate any of the following?:

1. Cancer, leukemia, multiple myeloma or tumor(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No	2. Hemophilia or other blood clotting disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Heart attack, heart surgery, congestive heart failure, heart valve disorder or other heart/vascular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	4. Aplastic anemia, Sickle Cell Anemia, other anemia, agranulocytosis, thrombocytopenia or other blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Stroke, transient ischemic attack (mini-stroke), aneurysm or other cerebrovascular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	6. Parkinson's Disease, Cerebral Palsy, epilepsy, migraines or other brain disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Emphysema, COPD, Cystic Fibrosis, asthma, other respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Hepatitis, cirrhosis or other liver disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
9. Multiple Sclerosis, Guillain-Barre, or other nervous system disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. HIV/AIDS or other immune suppressed disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
11. Lupus, Scleroderma or other auto-immune disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Disorder of pancreas or gallbladder? <input type="checkbox"/> Yes <input type="checkbox"/> No
13. Diabetes type I or II? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Skin disorder (psoriasis, eczema, acne, other)? <input type="checkbox"/> Yes <input type="checkbox"/> No
15. Disorder of kidney (failure or dialysis), or genitourinary system? <input type="checkbox"/> Yes <input type="checkbox"/> No	16. Congenital disorder or other birth defect? <input type="checkbox"/> Yes <input type="checkbox"/> No
17. GERD (acid reflux), stomach ulcers or other disorder of the esophagus? <input type="checkbox"/> Yes <input type="checkbox"/> No	18. Mental/emotional disorder, alcohol/substance abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No
19. Arthritis (osteo, rheumatoid, other), disorder of bones, joint, muscles tendon or cartilage? <input type="checkbox"/> Yes <input type="checkbox"/> No	20. Disorders of the spine, scoliosis, kyphosis, disc herniation, neck or back pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
21. Currently pregnant with a high risk pregnancy or birth defects, previous history of premature delivery, multiple gestation? Due date ? <input type="checkbox"/> Yes <input type="checkbox"/> No	22. Crohn's Disease, ulcerative colitis, diverticulitis, IBS or other disorder of the intestines? <input type="checkbox"/> Yes <input type="checkbox"/> No
23. Disorder of thyroid, pituitary, adrenal, other glands or requiring growth hormone? <input type="checkbox"/> Yes <input type="checkbox"/> No	24. Any stem cell or organ transplant (planned, recommended or already performed)? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Any other medical conditions or injury not mentioned elsewhere on this form for which hospitalization has occurred or other treatment has been received in the last 2 years or is anticipated in the next 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	26. Any medical conditions/illness resulting in medical expenses more than \$5000 in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No

Details

Complete the following for any "Yes" answers above - Attach additional pages if necessary

Question #	Individual's Name	Diagnosis and date of onset	Treatment and/or Medications	Provider, City, State	Ongoing?
					<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
					<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

I certify that the information contained in this medical disclosure questionnaire form is true and correct to the best of my knowledge. I understand intentional misstatements on this form may constitute insurance fraud and result in potential persecution and/or recession of coverage.

Signature of Applicant: _____

Date: _____