

# Small Group Individual Questionnaire



Applicant Name \_\_\_\_\_ SS# \_\_\_\_\_

Employer Name \_\_\_\_\_

THIS INFORMATION WILL BE USED TO EVALUATE MEDICAL RISK ONLY, NOT ELIGIBILITY FOR COVERAGE.

Applicant Height _____	Weight _____	Date of Birth _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Spouse* Height _____	Weight _____	Date of Birth _____	<input type="checkbox"/> Male	<input type="checkbox"/> Female
*Complete only if applying for dependent coverage.				

All questions must be answered YES or NO. Check YES, if anyone listed on the enrollment form has had signs or symptoms, or been treated or diagnosed by a healthcare provider for any of the conditions listed below within the past five years. You must provide details for any questions answered "yes" in the space below. If additional space is needed, please use a separate sheet of paper.

1. Are you or any dependent currently under any treatment or prescribed medication?  
If so, please list below and include name, dosage and frequency.  Yes  No
2. Have you or any dependent had unexplained weight loss/gain or fatigue in the past 12 months?  Yes  No
3. Have you or any dependent ever had or been diagnosed with, counseled, consulted or treated by a physician for any of the following: (please circle disease or disorder)
  - a. Chest pain, disease of heart, arteries or blood vessels, high or low blood pressure, high cholesterol.  Yes  No
  - b. Nervous, mental or emotional disorder, convulsions, epilepsy, unconsciousness, migraines, seizure  Yes  No
  - c. Asthma or other disease of lungs or respiratory organs, emphysema.  Yes  No
  - d. Kidney stones, disease of kidney, bladder, male or female organs or infertility  Yes  No
  - e. Cancer, and/or cancerous tumor (state type and body part)  Yes  No
  - f. Diabetes, liver or thyroid disease or enlargement of the lymph nodes, or disease of the pancreas  Yes  No
  - g. Stomach, gall bladder, intestinal or colon disorders  Yes  No
  - h. Rheumatoid arthritis, or back, muscle, joint or spinal disorders  Yes  No
  - i. Phlebitis, paralysis, or any other physical impairment or deformity  Yes  No
  - j. Alcoholism or drug habit, or been a member of Alcoholics Anonymous  Yes  No
4. Have you or any dependent been tested positive for exposure to HIV infection, or been diagnosed as having AIDS Related Complex or AIDS caused by the HIV, infection or other sickness or condition derived from such infection within the last 5 years?  Yes  No
5. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or advised to have surgery, had any injury, illness, medical advice or treatment, by a physician during the past 5 years for any reason not already mentioned?  Yes  No
6. Are you or any dependent pregnant or ever had a cesarean section?  Yes  No
7. Do you currently smoke cigarettes or any other tobacco related products?  Yes  No

