

General Information

Name (Last, First, MI)

Street Address

City

State

Zip

Phone

Home

Work

Mobile

Date of Birth

State of Birth

Gender

Height

Weight

Marital Status

Driver's License No.

Social Security No.

Company Name

Eligible Dependents to be Enrolled

Name (Last, First, MI)

Gender

Birth Date

Social Security No.

Height

Weight

Legal Spouse

Child 1

Child 2

Child 3

Health History

1. Have you or any person you are enrolling ever had, been medically advised they had, been treated for, or been referred to a physician for any of the following? Please check all that apply.

Disorders of the:	Heart	Arteries	Veins	Muscles
Cancer	Leukemia	Diabetes	Paralysis	Stroke
	Colon	Liver (including hepatitis)	Kidneys	Bladder
Immune Disorders	Aids	Positive test for HIV	Kaposi's Sarcoma	Chronic lung disorders
Alcoholism	Chemical, alcohol, or drug abuse or addiction		Used illegal drugs or prescription drugs other than as prescribed	
	Sexually transmitted diseases		Any nervous, mental or behavioral disorder	

2. Are you or any person you are enrolling currently taking prescribed medication, under medical treatment, or been advised of the possibility or necessity of future treatment or testing?

3. Is any person you are enrolling partially or totally disabled?

4. Are you or any family member, enrolling or not, currently pregnant?

If yes, Name:

Due Date:

Anticipated Complications?

Multiple births?

5. Have you or any family member, enrolling or not, experienced a complicated pregnancy?

Additional Health Questions

6. Have you or any person you are enrolling ever had, been medically advised they had, or been treated for any of the following? Please check all that apply.

Disease or disorder of the digestive system	Seizure disorder	Arthritis	Back Disorder
Other physical disorder or deformity	Medical claims exceeding \$10,000 in the last 12 months		

7. Has anyone applying for coverage smoked/used tobacco products in the last 12 months?

For all checked conditions as indicated above, please provide the following information:

Condition	Name of Patient	Last Date Seen	Condition/Diagnosis, Results of Treatment, and Medication