Individual Medical Questionnaire

COMPLETE INFORMATION ON ALL PAGES. SIGN AND DATE LAST PAGE.

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Section 1 – Employee Information

Full Name of Employee			Marital Status	
Residence Address		City	State	Zip
Telephone Number *(include area code)*		Best Time to Contact *(if additional information is required by administrator)*		
Date Began Full Time *(mm/dd/yy)*	DOB *(mm/dd/yy)*	Height	Weight	Social Security Number
Employed By	Employer's Phone *(include area code)*		Avg. No. of Hours Worked Weekly	
Employer's Location – Street Address		City	State	Zip
Occupation and Duties				

☐ I am an owner, partner or corporate officer ☐ I am **NOT** an owner, partner or corporate officer

I Am Enrolling For: ☐ Self Only ☐ Self & Spouse ☐ Self & Child(ren) ☐ Self, Spouse & Child(ren)

EMPLOYEE WAIVER

I am **NOT** enrolling because: ☐ Covered by another group/individual health plan. ☐ Other *(explain)* _____

DEPENDENT WAIVER

If you have dependents *(spouse and/or children)* and are not enrolling **ALL** of them, please complete the following:

I am **NOT** enrolling my *(check one or both)*: ☐ Spouse ☐ Child(ren) *(check one)*

Because: ☐ Covered by another group/individual health plan. ☐ Other *(explain)*

I understand I have the right to enroll my dependents at this time. I am voluntarily declining to enroll my dependents and have not been induced or pressured by anyone to decline such coverage. I understand that, if I do not enroll my dependents at this time, and they do not have other qualifying coverage, their right to enroll in the future may be restricted.

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Section 1 – Employee Information *(cont'd)*

PARTICIPANT INFORMATION – Complete for each person to be enrolled *(use additional sheet if necessary).*

Name of Participants	Relationship	Sex	Height	Weight	Date of Birth	SSN
1.						
2.						
3.						
4.						
5.						

Section 2 – Other Coverage

Do you or your dependents have coverage under any health benefit plan? ☐ Yes ☐ No

COVERAGE TYPE

☐ Comprehensive Major Medical	☐ Other *(please provide copy of the benefit plan or schedule of benefits)*
Name of Health Plan	Health Plan Phone Number
Effective Date of Prior Coverage	Termination Date
Reason for Coverage Termination	

PLAN TYPE

☐ Employer Sponsored	Employer Name	Policy/Cert. Number
☐ Individual	Policy/Cert. Number	

Coverage was for ☐ Self ☐ Spouse ☐ Children

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Section 3 – Medical History

1. In the past 5 years, have you or anyone enrolling for coverage had a diagnosis of, consultation, treatment or medication for:

	YES	NO
Brain or Nervous System		
Endocrine or Adrenal Disorder		
Liver, Pancreas or Kidney		
Abnormal Blood Pressure		
Heart or Circulatory System		
Chest Pain or Stroke		
Blood Disorder		
Lymphatic Vessels or Glands		
Cirrhosis or Hepatitis		
Leukemia or Hodgkin's Disease		
Cancer *(excluding Basal Cell Carcinoma)*		
Alcohol or Drug Abuse		
Congenital Disorders		
Respiratory disorders other than Emphysema, TB and COPD		

	YES	NO
Diabetes or Sugar in Urine		
Digestive or Gastrointestinal Disorder		
Breast or Reproductive Organs		
Autoimmune Disorders		
Disorders of Back or Spine		
Rheumatoid Arthritis		
Emphysema, Tuberculosis, Chronic Obstructive Pulmonary Disease		
Multiple Sclerosis or Cystic Fibrosis		
Skin or Collagen Disease		
Disease of the Muscles		
Arthritis other than rheumatoid		
Joint Disorders		
Mental/Emotional disorders		

2. Within the last 5 years, has anyone enrolling for coverage been diagnosed as having or been treated for human immunodeficiency virus (HIV) infection, any other acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC) condition, significant weight loss, chronic fatigue, diarrhea, night sweats or enlarged glands?

   ☐ Yes ☐ No

3. Are you or any dependent (whether enrolling for coverage or not) currently pregnant or anticipating surgery or hospitalization, or is anyone enrolling for coverage disabled, restricted or unable to perform the normal activities of daily living and self-care?

   ☐ Yes ☐ No 3a. If pregnant, please indicate due date _____

4. During the past 5 years, has anyone enrolling for coverage visited a doctor, had a medical consultation, had surgery, or been hospitalized?

   ☐ Yes ☐ No

5. Are you or any dependent enrolling for coverage currently taking medication?

   ☐ Yes ☐ No

6. For anyone enrolling for coverage, is there any existing medical condition or problem (including any undiagnosed symptoms) that has not otherwise been disclosed on this enrollment form?

   ☐ Yes ☐ No If "yes" answer, provide details below.

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Section 3 – Medical History *(cont'd)*

Complete the table below to provide details to any "YES" answer from questions 1 through 6 (above)

Use a separate sheet if additional space is needed. Sign and attach additional pages
If taking medication for high blood pressure, please include your **last three** blood pressure readings

Person	Medical condition or specific reason for treatment	Dates of Treatment	Meds. & Dosages	Recovery Status	Please list any treatment, surgery or anticipated surgery for this condition

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Section 4 – Employee Statement and Signature

I HEREBY: Request enrollment in the self-funded Group Health Plan (Plan) established and maintained by my employer (Employer) for its eligible employees and their eligible dependents; Represent that I am an eligible employee of the Employer; Represent that my statements and answers to the questions in this enrollment form are true and complete to the best of my knowledge and belief; and Authorize the Employer to deduct any required Plan contribution from my earnings.

I FURTHER ACKNOWLEDGE AND UNDERSTAND: This is not an insured benefit plan; All Plan benefits are self-funded (self-insured) by the Employer; The Employer is solely responsible for all benefit payments; Coverage is not effective until the Plan approves this enrollment form; Plan benefits are available only if a person is covered under, and all required contributions for such coverage have been received by, the Plan; If I have waived coverage for a dependent, I also waive all claims under the Plan for benefits for that dependent, and if I decide to enroll that person at a later date, the effective date for my dependent may be delayed; A full description of the medical expense benefits under the Plan appears in the Summary Plan Description, which summarizes the official Plan Document; The agent submitting this enrollment lacks authority to change the enrollment form, approve Plan coverage, alter Plan terms, or adjust claims; Underwriting Management Experts is not responsible for funding benefit payments; My statements and answers in this enrollment form will be the basis for approving Plan coverage and any material misrepresentation or omission may result in an increase in Plan contribution rates or termination of my coverage; Any person who, knowingly and with intent to defraud, submits an enrollment form, or files a claim, containing a materially false statement, or omitting materially false information, may be found guilty of fraud in a court of law.

SPECIAL ENROLLMENT RIGHTS: If you acquire a new dependent by marriage, birth, adoption or placement for adoption, he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days (of the marriage, birth, adoption or placement for adoption); If you decline enrollment for any dependent (including your spouse) because of other health plan or group insurance coverage, and that dependent subsequently becomes ineligible for the other coverage (or the employer stops contributing towards that coverage), he/she may be able to enroll without delay or penalty, if you request enrollment within 31 days of ineligibility or termination of employer contributions; If you decline enrollment for any dependent (including your spouse) because of coverage under Medicaid or a State child health plan, and that dependent's coverage is subsequently terminated due to ineligibility, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of the termination of coverage; If you decline enrollment for any dependent (including your spouse) and that dependent subsequently becomes eligible for a premium assistance subsidy from Medicaid or a State child health plan, he/she may be able to enroll without delay or penalty, if you request enrollment within 60 days of eligibility for the subsidy. To request special enrollment contact the Employer.

PERSONAL INFORMATION NOTICE: As required by law, this notice is intended to inform you that 1) Personal information may be collected from third parties; 2) Such information as well as other personal or privileged information collected by the health plan or its legal representative may be in certain instances, as prescribed by law, disclosed to other third parties without your prior authorization; 3) You have the right to access and correct the collected information; 4) Your right to access does not include any information which relates to and is collected in connection with, or in reasonable anticipation of, a claim or civil or criminal proceeding; 5) We will provide a more detailed notice of information practices upon request.

AUTHORIZATION FOR RELEASE OF INFORMATION: I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if applicable), including but not limited to employment status, other health plan coverage, diagnosis, prognosis, medical treatment or care, and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the health plan or its legal representative, agent or vendor, for the purpose of processing enrollment and claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment, but not the processing of claims, is conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the enrollment form; that a photocopy of this authorization shall be as valid as the original; that any documentation or information disclosed pursuant to this authorization may be re- disclosed and may no longer be covered by federal or state privacy laws; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Signature of Employee _____ Date _____

Electronic copies of this enrollment card submitted via facsimile, email, or other electronic means shall be deemed an original.