

EMPLOYEE ENROLLMENT/PERSONAL HEALTH QUESTIONNAIRE (PHQ)

All questions must be answered or the form may not be accepted.

Please choose from the following: New Applicant Coverage Change Information Update COBRA Applicant Waiver

Employee Name:		Employer Name:			
Home Phone:		Work Phone:			
Address:		City:	State:	ZIP Code:	
Email Address:		Marital Status:			
Date of Hire:	Currently Full Time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hours Worked per Week:	Salary:	
Occupation:	Division:	Is Spouse Employed?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Are you planning to enroll in your employer's health insurance plan? Yes No

*If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of page 2.

Covered by Spouse's Plan Do Not Want Coverage Not Eligible Other Reason _____

*If you selected "Yes", please complete the rest of this form.

Answer the following questions for yourself and eligible enrolling family members. Include additional sheets for detailed explanations or additional dependents.

Do you or your dependents described on this form have health coverage with another carrier? Yes No Effective Date: _____ Termination Date: _____

Who is covered? Self Spouse All Other Carrier Name: _____ Policy #: _____

Will you or your dependents continue coverage with other carrier? Yes No

Other coverage is through Individual Policy Spouse's Employer Medicare (if Yes, due to End Stage Renal Disease (ESRD)?)

I. Demographic, Build and Tobacco Use										
	Relation to Employee	Member Name	Social Security Number	Gender (M/F)	Date of Birth (mm/dd/yyyy)	Height		Weight (lbs)	Home Zip Code	Tobacco Use (Yes/No)
						Ft.	In.			
1	Employee									
2	Spouse									
3	Child									
4	Child									
5	Child									
6	Child									

II. Coverage Information					
MEDICAL PLAN Plan: _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> NONE	DENTAL PLAN Plan: _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> NONE	VISION PLAN Plan: _____ <input type="checkbox"/> Individual <input type="checkbox"/> Individual & 1 Child <input type="checkbox"/> Individual & Adult <input type="checkbox"/> Individual & Children <input type="checkbox"/> Family <input type="checkbox"/> NONE	LIFE INSURANCE <input type="checkbox"/> Life Insurance/AD&D <input type="checkbox"/> Supplemental Life Benefit: _____ <input type="checkbox"/> Dependent Life <input type="checkbox"/> NONE	SHORT TERM DISABILITY <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Voluntary STD Benefit: _____ <input type="checkbox"/> NONE	LONG TERM DISABILITY <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD <input type="checkbox"/> NONE
Life Insurance Beneficiary					
Beneficiary Name			Relationship		%

III. Medical Conditions and Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following? ***Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on page. 3 for ALL "YES" answers.

<p>1. Cancer (if yes, list location and type of cancer below) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Check One: <input type="checkbox"/> Stage 1 <input type="checkbox"/> Stage 2 <input type="checkbox"/> Stage 3 <input type="checkbox"/> Higher Date of Remission: (If Applicable)</p>	<p>6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Autoimmune Disease (i.e. lupus, MS,) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Back Disorder (i.e. degenerative disk disease) Herniated disk, spinal fusion, spondylitis, strain) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>2. Cardiac or Heart Disease/Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, check all that apply:</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> bypass surgery or angioplasty on single vessel, or</p> <p><input type="checkbox"/> bypass surgery or angioplasty on multiple vessels;</p> <p><input type="checkbox"/> ANY other heart conditions (list here) (i.e. arrhythmia, aneurysm, heart failure, heart valve disorder, pace maker)</p>	<p>9. Benign Growth (i.e. tumor, cyst) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Circulatory System Disease (i.e. stroke, arterial/vascular Diseases) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Kidney Disorder (i.e. nephritis, renal failure) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Mental Illness (i.e. mild or major depression, anxiety, Bipolar disorder or schizophrenia) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>3. Diabetes (if yes, list type 1 or 2) Type? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list 3 most recent HbA1c/fasting blood sugar levels:</p> <p>1) 2) 3)</p>	<p>15. Counseling <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Muscle/skeletal/bone/joint disorder <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Respiratory (i.e. asthma, allergies, pneumonia, COPD, Emphysema, bronchitis, sarcoidosis) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>4. High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list results from the 3 most recent readings:</p> <p>1) 2) 3)</p>	<p>18. Stomach (i.e. ulcer, acid reflux, GERD) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Substance Dependency (has anyone named in this application been evaluated or treated for alcoholism or chemical dependency, or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drug?) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>5. High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list results from the 3 most recent readings:</p> <p>1) 2) 3)</p>	<p>20. AIDS or HIV+ <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Transplants (if yes, list organ(s):) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Birth Defects <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>23. Neurological (CP, Parkinson's, Alzheimer's, Epilepsy, Paralysis) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>24. Blood Disorder (Anemia, Hemophilia) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

25. Is anyone currently taking **prescription medication(s)**? Yes No
26. Has anyone had any of the following for a **serious illness** in the past 5 years?
- a) treatment Yes No
- b) hospitalization Yes No
- c) surgery Yes No
27. Is anyone **currently**:
- a) hospitalized or confined in a treatment facility Yes No
- b) confined at home, incapacitated or incapable of self-support? Yes No
28. Is any of the following **pending**?
- a) treatment (medical treatment or diagnostic testing) Yes No
- b) hospitalization Yes No
- c) surgery Yes No
29. In the **past 5 years**, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form? Yes No

IV. Pregnancy and Childbirth

30. Is anyone **pregnant**? Yes No
- a) The due date is _____
- b) Is this a High Risk Pregnancy, any complications or bleeding? Yes No
- c) Previous C-Section or pre-term birth? Yes No
- d) Are multiple births expected? If so, please check Twins Triplets More Yes No

***If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE below, or this form will not be accepted.**

ADDITIONAL DETAIL TABLE – Please Fill in Details Below for All Questions Answered "YES"							
Question #	Name of Individual	Condition/Diagnosis	Date of Onset	Last Date Treated	Treatment/Drug	Still Taking (Y/N)	Degree of Recovery

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. NOTICE: A person who knowingly and with intent to misrepresent on this application or statement of claim containing any false, incomplete or misleading information may be subject to denied claims.

I understand that the following parties may need to provide or collect information on me or my Dependent Applicants: Group Benefit Services, Inc. (GBS) and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or Reinsurance Company, having information about me or any of my Dependent Applicants to provide all such information as requested by GBS or its Business Associates or Agents.

I understand that this Authorization may be needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to GBS.

I hereby authorize those physicians, medical practitioners, hospital, clinics, veteran's administration facilities, medical information services, urgent care facilities, pharmacy, pharmacy benefit manager, health plan, and other medical or medically related entities, insurance or reinsurance companies, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug or alcohol or domestic abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health care provider notes, laboratory tests and results, diagnoses, treatment, and prognoses. I understand the information obtained by use of this authorization may be used to determine eligibility for issuance of health coverage and eligibility for benefits under existing health coverage for me and my dependents. This authorization is not applicable to psychotherapy notes. I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for 2 ½ years from the date shown below. I further understand the information I authorize a person or entity to obtain and use may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent the Insurer and/or Plan Sponsor from the right to contest a claim if another law so allows. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Print Name _____

Applicant Signature: _____

Date Signed: _____