HEALTH INFORMATION QUESTIONS

Employer name_____

Employee	Sex: ☐ Male ☐ Female	Birthdate (mo/day/year)	Age	Height	Weight
Spouse	☐ Wife ☐ Husband				
Dependent Children	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				

1. Have you or any eligible dependent(s) ever had, been told you had, or been treated for any of the following:

a.	Heart/Circulatory Disorder?	☐ Yes ☐ No		j.	Liver Disorder?	☐ Yes ☐ No	
b.	High Blood Pressure?	☐ Yes ☐ No		k.	Gland Disorder?	☐ Yes ☐ No	
c.	Mental/Nervous, Emotional Disorders?	☐ Yes ☐ No		l.	Diabetes?	☐ Yes ☐ No	
d.	Alcoholism and/or Nerve Disorders?	☐ Yes ☐ No		m.	Developmental Disorder?	☐ Yes ☐ No	
e.	Stomach and/or Intestinal Disorder?	☐ Yes ☐ No		n.	Epilepsy, Seizures?	☐ Yes ☐ No	
f.	Multiple Sclerosis or Nerve Disorder?	☐ Yes ☐ No		o.	Lung, Respiratory Disorder?	☐ Yes ☐ No	
g.	Stroke/Paralysis?	☐ Yes ☐ No		p.	Bone, Joint, Muscle Disorder?	☐ Yes ☐ No	
h.	Cancer, Tumors?	☐ Yes ☐ No		q.	Severe Accident or Injury?	☐ Yes ☐ No	
i.	Kidney Disorder?	☐ Yes ☐ No		r.	Blood Disorder?	☐ Yes ☐ No	

2. Are you or any eligible dependent(s) currently receiving or recommended to receive medication or treatment? ☐ Yes ☐ No

3. Are you or any eligible dependent(s) currently pregnant? ☐ Yes ☐ No

4. Have you or any eligible dependent(s) ever:

a. Have had a surgery or advised to have a surgery in the past year? ☐ Yes ☐ No

b. Been declined or due to a health condition, received higher rates or had special conditions applied for Life, Major Medical, or Accident and Sickness Insurance? ☐ Yes ☐ No

c. Been confined to a hospital, sanitarium, or similar institution in the last year? ☐ Yes ☐ No

If any of the above questions is answered YES, on the reverse side state: Question number, name of person, detail of illness or accident, cost of expenses, date last treated for condition, the name of the physician and the city where treated.

5. Do you or any eligible dependent(s) have other health insurance in force with another company?

Name of person:_____Company:_____ Amount/Type of Coverage_____

Name of person:_____Company:_____ Amount/Type of Coverage_____

Name of person:_____Company:_____ Amount/Type of Coverage_____

Question Number	Name of Person	Details/Diagnosis of Illness or Accident	Total of Expenses in the Past 5 Years	Date Last Treated for Condition	Full Name and City and Phone Number for Doctor(s), Hospital(s) Where Treated

I hereby represent that I have read all statements, questions and responses in this Health Information Questions form (or they have been read to me) and I understand them; and my responses are true, accurate, complete and correctly recorded in all respects. The conditions and health history of me and members of my family are as stated above.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURER OR PERSON SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE INFORMATION OR A DEFECTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Signature of Applicant_____

Signed at City_____ **State**_____ **Date**_____