Employee Enrollment Information / Medical Questionnaire

Name of Employer:_____

Employee Last Name	First Name, MI	Gender	Last 4 of SSN#		Date of Birth
Street Address	**City**		**State**	**Zip**	**Phone Number**
Height		**Weight**			

Medical Coverage Selected: ☐ Single ☐ Single + Spouse ☐ Single + Child(ren) ☐ Family

Covered Dependent Name	Gender	Date of Birth	Currently Residing with You? (Y/N)	Has medical information been provided below?

Does Any Family Member have other medical insurance or Medicare? ☐ Yes ☐ No

If yes, who has other coverage and what is the Insurance Company Name? _____

Medical History Information:

Have you, or any covered person listed above received consultation or treatment for any of the following conditions in the past 2 years?

Yes	No		Yes	No		Yes	No	
☐	☐	Cancer/Neoplasm/Lymphoma	☐	☐	Leukemia	☐	☐	Lung Disease/Disorder
☐	☐	Arthritis	☐	☐	Connective Tissue Disorders	☐	☐	Multiple Sclerosis
☐	☐	Diabetes	☐	☐	Heart or Blood Disorder	☐	☐	Myasthenia Gravis
☐	☐	CVA / Stroke	☐	☐	Back/Joint Disorder	☐	☐	Neurological Disorder
☐	☐	Injuries	☐	☐	Cerebral Palsy/Cystic Fibrosis	☐	☐	Any Pending Surgery
☐	☐	Hypertension	☐	☐	Hyper or Hypothyroid	☐	☐	Or Condition > $10k in Claims
☐	☐	Congenital Disorder	☐	☐	Pregnancy Complications	☐	☐	Liver Disorders
☐	☐	Sickle Cell	☐	☐	Stomach/Intestinal Disorders	☐	☐	Renal Disorders
						☐	☐	Chronic Psychiatric Disorders

Explain all Conditions Checked above in the table below.

Patient Name	Current Diagnosis	Date Diagnosed (Mo/Yr)	Type of Ongoing Care	List Prescription Medications

If you require more room, please use the back of this form.

I certify that the information contained in this enrollment information / medical questionnaire form is true accurate to the best of my knowledge. I understand that intentional misstatements on this form may constitute fraud and will result in the rescission of coverage. This information is not being utilized to determine if you or any dependents are eligible to enroll in coverage. It is being utilized to determine benefit availability according to the plan sponsored by your Employer.

Signature: _____ Date: _____