

**HEALTH QUESTIONNAIRE**  
2 – 50 ELIGIBLE EMPLOYEES

**Note:** Please print clearly and complete all applicable items on the front and back of this form. Do not complete shaded areas. Inaccurate, incomplete or illegible information may delay your coverage. Please submit this completed Health Questionnaire along with your completed Enrollment Application.

**GROUP NAME** \_\_\_\_\_

**1. EMPLOYEE INFORMATION**

Employee Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

**2. ENROLLEE INFORMATION**

**Note:** Do not list dependents who will not be enrolled. Use a separate sheet to list additional enrollees.

Relationship to Employee	Name (Last, First, MI)	Gender	Date of Birth	Height	Weight
Self	Self	<input type="checkbox"/> M <input type="checkbox"/> F	/ /	ft. in.	lbs.
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	ft. in.	lbs.
Child		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	ft. in.	lbs.
Child		<input type="checkbox"/> M <input type="checkbox"/> F	/ /	ft. in.	lbs.

**3. HEALTH INFORMATION FOR EMPLOYEE AND ALL ENROLLING DEPENDENTS**

**Note:** Please answer the following questions concerning yourself and any of your dependents **who will be covered by this plan.**

**A. Health Condition Selection**

Have you or any family member to be covered on this plan ever had, been advised of, diagnosed with, received treatment for, or had treatment recommended for any of the following conditions? Please check each item either YES or NO. **If yes, please provide details in section 3B.**

**Notice To Applicants:** Each applicant, including any family member listed on this form, must provide information on diseases and disorders for which he or she has symptoms. Do not provide any information on any part of this application about genetic testing or genetic information relating to you or to any family member, including any decision by an insurance company that is based on a genetic test or on genetic information.

- |  |  |  |                                   |
|--|--|--|-----------------------------------|
| 1. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Acquired Immune Deficiency Syndrome (AIDS) | 18. <input type="checkbox"/> No <input type="checkbox"/> Yes | Gastrointestinal Conditions       |
| 2. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Alcoholism                                 | 19. <input type="checkbox"/> No <input type="checkbox"/> Yes | Heart Conditions                  |
| 3. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Allergies                                  | 20. <input type="checkbox"/> No <input type="checkbox"/> Yes | Hepatitis                         |
| 4. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Aneurysm                                   | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Type A                            |
| 5. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Asthma                                     | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Type B                            |
| 6. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Back Disorder                              | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Type C                            |
| 7. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Blood Disorders                            | 21. <input type="checkbox"/> No <input type="checkbox"/> Yes | High Blood Pressure               |
| 8. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Bipolar                                    | 22. <input type="checkbox"/> No <input type="checkbox"/> Yes | High Cholesterol                  |
| <input type="checkbox"/> No <input type="checkbox"/> Yes     | Counseling?                                | 23. <input type="checkbox"/> No <input type="checkbox"/> Yes | HIV or ARC                        |
| 9. <input type="checkbox"/> No <input type="checkbox"/> Yes  | Cancer                                     | 24. <input type="checkbox"/> No <input type="checkbox"/> Yes | Kidney Failure                    |
| Type _____   |  | 25. <input type="checkbox"/> No <input type="checkbox"/> Yes | Lupus                             |
| 10. <input type="checkbox"/> No <input type="checkbox"/> Yes | Cerebral Palsy                             | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Systemic                          |
| 11. <input type="checkbox"/> No <input type="checkbox"/> Yes | Cirrhosis                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Discoïd                           |
| 12. <input type="checkbox"/> No <input type="checkbox"/> Yes | Congenital Conditions                      | 26. <input type="checkbox"/> No <input type="checkbox"/> Yes | Multiple Sclerosis                |
| 13. <input type="checkbox"/> No <input type="checkbox"/> Yes | COPD                                       | 27. <input type="checkbox"/> No <input type="checkbox"/> Yes | Muscular Dystrophy                |
| 14. <input type="checkbox"/> No <input type="checkbox"/> Yes | Depression                                 | 28. <input type="checkbox"/> No <input type="checkbox"/> Yes | Osteoarthritis                    |
| <input type="checkbox"/> No <input type="checkbox"/> Yes     | Counseling?                                | Joint(s) Involved _____                                      |                                   |
| 15. <input type="checkbox"/> No <input type="checkbox"/> Yes | Diabetes Type I                            | 29. <input type="checkbox"/> No <input type="checkbox"/> Yes | Parkinson's Disease               |
| <input type="checkbox"/> No <input type="checkbox"/> Yes     | Diabetes Type II                           | 30. <input type="checkbox"/> No <input type="checkbox"/> Yes | Pituitary Disorders               |
| 16. <input type="checkbox"/> No <input type="checkbox"/> Yes | Drug Abuse                                 | 31. <input type="checkbox"/> No <input type="checkbox"/> Yes | Pregnant                          |
| Name of Drug(s) _____  |  | Due Date _____   |                                   |
| 17. <input type="checkbox"/> No <input type="checkbox"/> Yes | Emphysema                                  | <input type="checkbox"/> No <input type="checkbox"/> Yes     | Complications or Multiple Births? |

**3. HEALTH INFORMATION FOR EMPLOYEE AND ALL ENROLLING DEPENDENTS (CONTINUED)**

**A. Health Condition Selection (Continued)**

Have you or any family member to be covered on this plan ever had, been advised of, diagnosed with, received treatment for, or had treatment recommended for any of the following conditions? Please check each item either YES or NO. **If yes, please provide details in section 3B.**

**Notice To Applicants:** Each applicant, including any family member listed on this form, must provide information on diseases and disorders for which he or she has symptoms. Do not provide any information on any part of this application about genetic testing or genetic information relating to you or to any family member, including any decision by an insurance company that is based on a genetic test or on genetic information.

- |   |   |
|---|---|
| <p>32. <input type="checkbox"/> No <input type="checkbox"/> Yes Rheumatoid Arthritis</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Asymptomatic</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Mild, non-disabling</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Chronic/Severe</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Surgery Anticipated</p> <p>33. <input type="checkbox"/> No <input type="checkbox"/> Yes Seizures</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes Medications?</p> <p>Date of last Seizure _____</p> <p>34. <input type="checkbox"/> No <input type="checkbox"/> Yes Senile Dementia</p> <p>35. <input type="checkbox"/> No <input type="checkbox"/> Yes Stroke</p> <p>36. <input type="checkbox"/> No <input type="checkbox"/> Yes Transplants (bone marrow, heart, kidney, liver, lung or pancreas)</p> | <p>37. <input type="checkbox"/> No <input type="checkbox"/> Yes Tumor</p> <p>Location _____</p> <p>38. <input type="checkbox"/> No <input type="checkbox"/> Yes Have any claims over \$5,000 been billed in the last 18 months?</p> <p>39. <input type="checkbox"/> No <input type="checkbox"/> Yes Are there any Ongoing Disabilities?</p> <p>40. <input type="checkbox"/> No <input type="checkbox"/> Yes Any other condition(s) not listed?</p> <p>If yes, explain:</p> <p>_____</p> <p>_____</p> <p>_____</p> |
|---|---|

**B. Health Condition Explanation**

*Note: Please provide detailed information for all items checked Yes in section 3A. Use a separate sheet to list additional details.*

Condition Number from 3A	Person's Name	Treatment Dates	Further Treatment Needed?	Treatment Details
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	
		From: / / To: / /	<input type="checkbox"/> No <input type="checkbox"/> Yes	

**4. EMPLOYEE SIGNATURE**

I declare that to the best of my knowledge, all of the information on this form is true and complete, and all of the persons for whom I am requesting enrollment are eligible for coverage. It is understood that Premera Blue Cross Blue Shield of Alaska will apply this information as part of the group rate determination process only. I understand that if I have misstated or omitted any information on this form, Premera Blue Cross Blue Shield of Alaska may reassess rates charged to my employer group or terminate Premera Blue Cross Blue Shield of Alaska coverage in accordance with applicable law.

Employee Signature: **X** \_\_\_\_\_

Date: / / Daytime Contact Number: \_\_\_\_\_

**Please note:** A person who, with intent to injure, defraud, or deceive, knowingly makes a false or fraudulent statement or representation in or with reference to an application for insurance may be prosecuted under state law.

Premera Blue Cross Blue Shield of Alaska may collect, use and disclose protected personal information (PPI) about each individual enrolled under this application in order to carry out its routine business functions, which include, but are not limited to, determining eligibility for benefits, paying claims, coordinating benefits with other insurance carriers or payers, underwriting, and conducting case management, care management and quality reviews. Premera Blue Cross Blue Shield of Alaska may also disclose PPI to state and/or federal agencies, or other third parties, as required or permitted by law.