

**HEALTH QUESTIONNAIRE**  
51-99 ENROLLED EMPLOYEES

**Note to Employee:** Please print clearly and complete all applicable items. 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. HEALTH INFORMATION**

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

**A.** Are you or any dependents now disabled or unable to perform normal activities?  No  Yes

Name \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B.** Have you or any dependents visited a healthcare professional for any illness and/or medical condition resulting in medical expenses more than \$5,000 in the past 12 months?  No  Yes

Name \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C.** Have you or any dependents been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?  No  Yes

Name \_\_\_\_\_ Reason \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. 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 \_\_\_\_\_ Date Signed \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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.

Premera Blue Cross Blue Shield of Alaska Use Only CR-WP Waive-WP From U/W Approval