

# Group Medical Questionnaire

## Medical Profile

Plan Sponsor Representative (Benefit Administrator, Officer): Please answer the following questions for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than \$10,000 been paid or incurred in the last 12 months?  Yes  No

B. Within the past 24 months, has any employee or dependent had any claim (on-going treatment, medication, doctor visitors, lab tests) due to a mental or physical disorder?  Yes  NO If "Yes," check the appropriate box(es) below.

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|--|--|--|--|
| <input type="checkbox"/> AIDS/Immune Disorders | <input type="checkbox"/> Cardiovascular        | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Migraines           |
| <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Infertility         | <input type="checkbox"/> Neurological        |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Drug/Substance Abuse  | <input type="checkbox"/> Intestines          | <input type="checkbox"/> Pancreas            |
| <input type="checkbox"/> Back, Neck            | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Kidney              | <input type="checkbox"/> Skin                |
| <input type="checkbox"/> Blood                 | <input type="checkbox"/> Ears/Eyes             | <input type="checkbox"/> Liver               | <input type="checkbox"/> Stomach             |
| <input type="checkbox"/> Bone/Joint            | <input type="checkbox"/> Emphysema/Pulmonary   | <input type="checkbox"/> Lungs               | <input type="checkbox"/> Stroke/Paralysis    |
| <input type="checkbox"/> Brain                 | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Lupus               | <input type="checkbox"/> Venereal            |
| <input type="checkbox"/> Cancer/Tumor          | <input type="checkbox"/> High Risk Pregnancies | <input type="checkbox"/> Mental/Nervous      | <input type="checkbox"/> Other, Detail below |

C. Are any employees or dependents pregnant?  Yes  No If "Yes," how many? \_\_\_\_\_  
 Any high risk pregnancies?  Yes  No If "Yes," how many? \_\_\_\_\_  
 Any multiple births expected?  Yes  No If "Yes," how many? \_\_\_\_\_

D. Has anyone been recommended for surgery or hospitalization for a mental or physical disorder?  Yes  NO

If you answered "Yes" to question A, B or D, please provide the following information for each individual with a continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	\$ Amount of Prior Claims	Prognosis / Current Treatment

The information on this form is designed to assist in evaluation of your group. The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please Print)	Prospective Applicant Signature	Date
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