HEALTH QUESTIONNAIRE

Current Height _____

Current Weight _____

NAME _____

NOTICE TO APPLICANT: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS in the Health Questions Sections. If any question in Section 1 is answered "YES", the applicant is not eligible for coverage. If any question(s) in Section 2 is answered "YES", the applicant may be eligible for coverage. Please verify the accuracy and completeness of the health information on this application. Incomplete or false information could jeopardize future claims.

HEALTH QUESTIONS SECTION # 1

…….IF ANY QUESTION 1-8 IS ANSWERED "YES", THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE…….

1. Are you currently:

A. Hospitalized confined to a nursing facility, bedridden or require the use of a wheelchair or motorized mobility aid? YES ☐ NO ☐

B. Receiving hospice, home health care or physical therapy? YES ☐ NO ☐

2. Have you ever been medically diagnosed or treated for diabetes:

A. That requires insulin or more than (**2**) two oral medications? YES ☐ NO ☐

B. With history of heart attack, stroke or any kidney disease? YES ☐ NO ☐

C. With complications including retinopathy, neuropathy or peripheral vascular disease? YES ☐ NO ☐

3. If you have diabetes in conjunction with high blood pressure, have there been any changes or adjustments in your medications because of uncontrolled blood sugar in the past 24 months? YES ☐ NO ☐
(If you do not have diabetes this question should be answered **"NO"**)

4. Have you ever had or been advised to have any bone marrow transplant, stem cell transplant, an organ transplant or any amputation caused by disease? YES ☐ NO ☐

5. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:

A. Alzheimer's disease, senile dementia, or any other cognitive disorder? YES ☐ NO ☐

B. Emphysema, chronic obstructive pulmonary disease (COPD), sarcoidosis, or any pulmonary condition treated with supplemental oxygen or a nebulizer? YES ☐ NO ☐

C. Parkinson's disease, multiple sclerosis, amyotrophic lateral sclerosis (Lou Gehrig's disease), muscular dystrophy or cerebral palsy? YES ☐ NO ☐

D. Lupus, scleroderma, myasthenia gravis or Paget's disease? YES ☐ NO ☐

E. Osteoporosis with fracture(s), crippling/disabling arthritis or rheumatoid arthritis? YES ☐ NO ☐

F. Chronic hepatitis, cirrhosis of the liver, Crohn's disease or ulcerative colitis? YES ☐ NO ☐

G. Retinopathy, wet macular degeneration or any eye condition that required injection(s)? YES ☐ NO ☐

H. Addison's disease, Hodgkin's Disease, kidney failure or ever had kidney dialysis? YES ☐ NO ☐

I. Congestive heart failure or a cardiac defibrillator? YES ☐ NO ☐

J. Lymphoma, leukemia, multiple myeloma or more than (1) one occurrence of internal cancer? YES ☐ NO ☐

K. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? YES ☐ NO ☐

6. Within the past (5) five years, have you been treated for, or been advised to have treatment for;

A. Hepatitis C, alcoholism, drug abuse, or had a mental or nervous disorder requiring a hospital confinement? YES ☐ NO ☐

B. Any condition that resulted in chemotherapy or radiation treatments? YES ☐ NO ☐

C. Osteopenia, Osteoporosis or any Arthritic condition whereas treatment included infusions(s) or injection(s)? YES ☐ NO ☐

7. Within the past (2) two years, have you been treated for, or been advised to have treatment for:

A. Heart attack, cardiomyopathy, an enlarged heart, Stroke or transient ischemic attack (TIA)? YES ☐ NO ☐

B. Coronary bypass surgery, heart valve surgery, aneurysm, angioplasty, or vascular surgery including stent(s) placement and or artery blockage? YES ☐ NO ☐

C. Heart rhythm disorder, Atrial fibrillation (AFIB) or have you had a pacemaker implanted? YES ☐ NO ☐

D. Any form of Internal cancer or melanoma? YES ☐ NO ☐

HEALTH QUESTIONS SECTION # 1 (continued)

8. Within the past (3) three years, have you been advised by a medical professional to have any:

A. Treatment(s), further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results? YES ☐ NO ☐

B. Cataract surgery which has not been performed or which is anticipated in the next 12 months? YES ☐ NO ☐

HEALTH QUESTIONS SECTION # 2

……IF ANY QUESTION 9-15 IS ANSWERED "YES", YOU MAY BE ELIGIBLE FOR COVERAGE……

Consideration will be based on information obtained in conjunction with medications and treatments for any and/or all conditions listed below.

9. At any time have you been medically diagnosed with, treated for, or had surgery for any of the following:

A. Heart attack, angioplasty, aneurysm, any type of heart or vascular surgery including stent(s), artery blockage, heart rhythm disorders (AFIB) or had a pacemaker implanted? YES ☐ NO ☐

B. Stroke or transient ischemic attack (TIA) YES ☐ NO ☐

C. Any form of Internal cancer, melanoma or blood disorder? YES ☐ NO ☐

D. Chronic Kidney disease or do you have only one Kidney? YES ☐ NO ☐

10. Do you have asthma or any non-chronic pulmonary condition which requires the use of medications, including inhalers? YES ☐ NO ☐

11. Within the past (3) three years have you had any infusions, injections, or transfusions in a medical facility or are any anticipated in the next 12 months (excluding vaccinations)? YES ☐ NO ☐

12. Within the past (2) two years, have you had ***any*** surgeries, physical therapy, or joint replacements? YES ☐ NO ☐
(If YES, you must be fully released from physician for a period of more than 60 days for consideration)

13. Within the past (2) two years, have you been hospitalized, under observation care in a hospital, or have you received treatment in an Emergency Room for any reason? YES ☐ NO ☐

List any other significant diseases or disorders not listed above

Please explain any "YES" answer(s) for questions 9-13 including condition treated, treatment method, beginning and end dates of treatment, etc..

HEALTH QUESTIONS SECTION # 2 (continued)

14. Are you taking or have you taken any prescription medications within the past **24 months**?
If YES, please list the information below for each medication. (attach a separate sheet if needed) YES ☐ NO ☐

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

	Medication Name	
	Dosage and Frequency	
	Diagnosis/Medical Condition	
	Date Originally Prescribed	

Please provide complete name, address and telephone number of the proposed insured's primary care physician:

Physician's Name_____Telephone (_____)_____

Address_____City_____State_____Zip_____

Date last seen _____Reason_____

Please provide name(s) of any other physicians or specialists you have visited in the past (24) twenty-four months:

Name_____(specialty)_____

Date last seen _____Reason_____

Name_____(specialty) _____

Date last seen _____Reason_____

Name_____(specialty)_____

Date last seen _____Reason_____

15. Have you seen any additional physicians other than those listed above in the past 24 months? YES ☐ NO ☐