PriorityHealth

# Health questionnaire

This health questionnaire is used to develop a proposal for group health coverage with your employer. The information you provide is kept **strictly confidential** and is used by Priority Health for rating purposes only, not to determine your eligibility for coverage. This information is not shared with your employer unless you choose to do so.

**Instructions:**

1. Provide information about your spouse and dependents. If you need additional space, attach a separate sheet. Be sure to sign and date all additional pages.
2. Please complete the health questionnaire clearly and in full or it will be returned to you, resulting in a delay in processing. Incomplete questionnaires may delay the effective date of your coverage.
3. Read carefully and sign the enclosed authorization.

## Employee information

| Employer name | | | | | |
|---|---|---|---|---|---|
| Employee last name | Employee first name | | | Average # of hrs/week | Date of hire |
| Home address | | | | Phone number | |
| City | | | State | ZIP code | |
| Marital Status ☐ Single ☐ Married | Gender ☐ Male ☐ Female | Birth date (mm/dd/yyyy) | Age | Height | Weight |

## Spouse and dependent information

**1**

| Spouse last name | First name | | Gender ☐ Male ☐ Female | |
|---|---|---|---|---|
| | Birth date (mm/dd/yyyy) | Age | Height | Weight |

**2**

| Dependent last name | First name | | Gender ☐ Male ☐ Female | |
|---|---|---|---|---|
| Relationship to employee | Birth date (mm/dd/yyyy) | Age | Height | Weight |

**3**

| Dependent last name | First name | | Gender ☐ Male ☐ Female | |
|---|---|---|---|---|
| Relationship to employee | Birth date (mm/dd/yyyy) | Age | Height | Weight |

## Health information

In the past 5 years, have you or any person applying for coverage been diagnosed with, advised of, tested for, had or been in need of treatment or surgery for any condition related to the following:

1. ○ Yes ○ No Are you or any immediate family member pregnant, or an expectant parent, or in the process of adoption, whether or not that person is listed on this application?

2. ○ Yes ○ No Any heart or circulatory system disorders including high blood pressure, high cholesterol, anemia, clogged arteries, atherosclerosis, heart attack, chest pain, stroke, TIA, heart valve disorder, irregular heart beat, pacemaker, heart murmur, atrial fibrillation, angioplasty, heart bypass surgery, atrial septal defect, aortic insufficiency, congestive heart failure, cardiomegaly, cardiomyopathy, aneurysm, bleeding or clotting disorder, hemophilia, varicose veins or heart transplant?

3. ○ Yes ○ No Any respiratory system disorders including lung disease, emphysema, asthma, chronic cough, tuberculosis, cystic fibrosis, chronic obstructive pulmonary disease (COPD), bronchitis, pneumonia or lung transplant?

4. ○ Yes ○ No Any digestive system disorders including diseases of the pancreas, liver or gallbladder, hepatitis, cirrhosis, fatty liver, gastric bypass or banding, eating disorders, GERD, Crohn's disease, gastrointestinal disorder, ulcer, ulcerative colitis or liver or pancreas transplant?

5. ○ Yes ○ No Any musculoskeletal system disorders including back, spine or neck disorders, arthritis, hip or knee replacement, amputation or prosthesis, lupus, fibromyalgia or connective tissue disorder?

6. ○ Yes ○ No Any nervous system or mental disorders including psychoses, depression, anxiety, epilepsy, seizure, multiple sclerosis, muscular dystrophy, myasthenia gravis, paralysis, Parkinson's disease, cerebral palsy, schizophrenia, bipolar/ manic depressive disorder, senile dementia, Alzheimer's or amyotrophic lateral sclerosis (ALS/Lou Gehrig's disease)?

7. ○ Yes ○ No Any endocrine and metabolic system disorders including diabetes, elevated blood sugar or presence of any protein, albumin or sugar in the urine, thyroid, adrenal or pituitary disorders?

8. ○ Yes ○ No Any genital, reproductive or urinary system disorders including blood in urine, infertility, irregular menstruation, ovary disorder, abnormal PAP, cystitis, stones, prostate disorder, sexually transmitted diseases, complications of pregnancy (including caesarean section), kidney stones or disease, end stage renal disease (ESRD), kidney transplant or dialysis?

9. ○ Yes ○ No Any tumors, cysts, birth defects or congenital abnormalities including cleft lip or palate, autism, Down's syndrome, congenital heart defect, mental retardation or other physical deformities?

10. ○ Yes ○ No Any acquired immune deficiency syndrome disorder (AIDS), chronic fatigue, AIDS-related complex (ARC) or ever tested positive for the human immunodeficiency virus (HIV+) ?

11. ○ Yes ○ No Any cancers, including melanoma, leukemia, Hodgkin's disease, lymph glands/node, bone marrow or stem cell transplant?

12. ○ Yes ○ No Any eyes and ears disorders including glaucoma, retinopathy, cataract, corneal transplant or loss of hearing?

13. ○ Yes ○ No Any tobacco or nicotine product use in the last 12 months?

14. ○ Yes ○ No Any alcoholism or alcohol abuse, drug use including cocaine, heroin and narcotics, chemical dependency or recommended for drug or alcohol counseling, or driving while intoxicated (DUI)?

15. ○ Yes ○ No Any medical or physical impairment or take any medications or receive medical treatment for any conditions not already mentioned?

16. ○ Yes ○ No Any testing, surgery, treatment, therapy, medications or hospitalization recommended or advised and not yet completed?

17. ○ Yes ○ No Any history of breast implants or internal fixations (plates, screws, pins, shunts, stents, etc.)?

**Please give details about any "yes" answers in the section on the next page.**

Subscriber initials _____

# Health questionnaire

PriorityHealth

Please provide details to any "yes" answers in the following section. Please include full details including person, condition, treatment, prescription drugs, hospitalization, dates and current condition. If additional space is needed, please continue on another page (please sign and date that page).

| Question # | Applicant name | Condition | Date diagnosed | Date last treated | Treatment, including medication names with dosage and how-often taken |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

## Other information

1. ○ Yes ○ No Has anyone applying for coverage ever been covered by Priority Health insurance? If yes, please provide details including name, dates covered, employer name:

_____

_____

_____

2. ○ Yes ○ No Have you or any person applying for coverage ever been declined, postponed or had conditions excluded or charged an additional premium for any health, life or disability insurance coverage? If "yes", please provide details: name, when and why:

_____

_____

_____

3. ○ Yes ○ No Is anyone, or has anyone applying for coverage been disabled, hospitalized, confined or unable to work due to a medical condition? If yes, please provide details:

_____

_____

_____

Subscriber initials _____

# Health questionnaire

PriorityHealth

Priority Health requires proper handling of individually identifiable health information for applicants and members, and details of confidentiality policies and procedures are available upon written request to Priority Health.

I understand that the following parties may need to provide or collect information on me or my dependent applicants in regard to this questionnaire: Priority Health and its reinsurers and authorized Business Associates. I authorize the entities having information about me or any of my dependents to provide such information as requested to Priority Health or its Business Associates or Agents as may be required for rating purposes.

Unless revoked earlier, this authorization will be valid for a period of thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to Priority Health at: 1231 E Beltline, NE, MS 1175, Grand Rapids, MI 49525. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of this health information is voluntary and will be used for self-funded group underwriting purposes. I can refuse to sign this authorization. I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information in which case it may no longer be protected by federal rules governing privacy and confidentiality. I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified.

I declare that the answers and information presented on this application are complete and true for all applicants to the best of my knowledge and belief. This is not an application for coverage.

Subscriber (primary applicant) signature _____ Date _____