



**Health Questions (For Employees Applying for Amounts of Insurance over the Guaranteed Issue Limit, Enrolling Late, Increasing Coverage, or Enrolling again after having Cancelled Coverage)**

Last Name	First Name	Middle Initial	Social Security No.
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Please answer the following questions.

If you answer "YES" to any questions, please provide details in REMARKS below.

Height \_\_\_\_\_ Weight \_\_\_\_\_

1. Have you gained or lost 10 or more pounds during the past 12 months?  
If "YES", how much? \_\_\_\_\_  Yes  No
2. Have you within the past 5 years:  Yes  No
  - a. Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?
  - b. Used any illegal drugs?  Yes  No
3. In the past 5 years, have you had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?  Yes  No
4. Have you ever been diagnosed as having acquired immunodeficiency syndrome (AIDS)?  Yes  No
5. Are you pregnant?  Yes  No
6. Have you ever had, been medically diagnosed, treated or been advised to seek treatment for: Arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; or immune system disorder?  Yes  No

"Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.

Name, address and telephone number of personal physician \_\_\_\_\_

**REMARKS** – If you answered "YES" to any health question above, please provide details below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question No.	First Name	Description of illness, injury, or pregnancy, medication or treatment	Duration (dates) & No. of episodes	Residual effects/ results	Name and address of attending physician or hospital (include zip code)

**If Answering Health Questions, the Employee signature is required on page 4 of this form.**