



# GROUP MEDICAL QUESTIONNAIRE

**4 - 50 GROUP SIZE**

## GENERAL INFORMATION

**GROUP NAME:** \_\_\_\_\_

**EFFECTIVE DATE:** \_\_\_\_\_

## MEDICAL HISTORY

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children).

Within the past 12 months, has any employee or dependent had a continuing claim (i.e. chronic or ongoing) due to any of the conditions below? Please check the appropriate box(es).

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

If you have checked any of the above conditions, using your best existing knowledge please complete the following for each affected employee/dependent.

CONDITION	MEDICATION	YEARS OF TREATMENT

*This information will be used to determine the medical risk associated with this group. The undersigned Authorized Company Officer hereby acknowledges that the information on this form is complete and true to the best of his or her knowledge. The undersigned Authorized Company Officer further represents that the summary health information provided above was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.*

Authorized Company Officer:

**Name/Title (Print):** \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_