



**MEDICAL QUESTIONNAIRE FOR LATE ENROLLEES**

Applicant: \_\_\_\_\_

SSN: \_\_\_\_\_

All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. **YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH CONDITIONS.** However, **FAILURE TO REVEAL ALL MEDICAL INFORMATION IN A MANNER CONSTITUTING FRAUD OR INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MAY RESULT IN RESCISSION OF COVERAGE.**

- Yes**  **No** Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? If "Yes," Member: \_\_\_\_\_ Reason: \_\_\_\_\_
- Yes**  **No** Has any person to be insured ever been insured with Arkansas Blue Cross and Blue Shield or Health Advantage? If "Yes," Member \_\_\_\_\_
- Yes**  **No** Has any person to be insured used tobacco in the last 12 months? If "Yes", Member: \_\_\_\_\_ What Type? \_\_\_\_\_

In the past 10 years, has any person to be insured ever been diagnosed or been advised to have treatment or care for any of the following conditions? **Check the appropriate box(es) below and explain in the Additional Medical Information section.**

- |                                   |                                   |  |                                   |                                   |  |                                   |                                   |   |
|-----------------------------------|-----------------------------------|--|-----------------------------------|-----------------------------------|--|-----------------------------------|-----------------------------------|---|
| <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | 4. Heart Condition   | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | 15. Cyst or Tumor  | <b>Y</b> <input type="checkbox"/> | <b>N</b> <input type="checkbox"/> | 25. Stroke or Seizure<br># of episodes: _____ |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 5. Circulatory Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 16. AIDS or HIV positive   | <input type="checkbox"/>          | <input type="checkbox"/>          | 26. Drug Abuse<br>Name of Drug: _____         |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 6. Pancreatic Disorder   | <input type="checkbox"/>          | <input type="checkbox"/>          | 17. Immune Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 27. Cancer<br>Type: _____                     |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 7. Lung Problem  | <input type="checkbox"/>          | <input type="checkbox"/>          | 18. Digestive Disorder   | <input type="checkbox"/>          | <input type="checkbox"/>          | 28. Arthritis<br>Type: _____                  |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 8. COPD or Asthma  | <input type="checkbox"/>          | <input type="checkbox"/>          | 19. Kidney Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 29. Hepatitis<br>Type: _____                  |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 9. Brain Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 20. Bladder/Prostate Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 30. Currently Pregnant<br>Due Date: _____     |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 10. Mental Disorder  | <input type="checkbox"/>          | <input type="checkbox"/>          | 21. Recurrent Pain   | <input type="checkbox"/>          | <input type="checkbox"/>          | 31. Any Condition not listed above?<br>_____  |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 11. Depression   | <input type="checkbox"/>          | <input type="checkbox"/>          | 22. Reproductive Disorder  |                                   |                                   |   |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 12. Anxiety  | <input type="checkbox"/>          | <input type="checkbox"/>          | 23. Liver Disorder   |                                   |                                   |   |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 13. Alcohol Abuse  | <input type="checkbox"/>          | <input type="checkbox"/>          | 24. Diabetes or High Blood Sugar<br>Type: _____ and _____                        |                                   |                                   |   |
| <input type="checkbox"/>          | <input type="checkbox"/>          | 14. High Blood Pressure<br>Last 3 readings: _____/_____/_____<br>_____/_____/_____; _____/_____/_____<br>_____/_____/_____ |                                   |                                   | If <b>yes</b> , provide last 3 fasting blood sugar readings: _____; _____; _____ |                                   |                                   |   |

- Yes**  **No** In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? (If "Yes" give full details in the Additional Medical Information Section below.)
- Yes**  **No** Has any person to be insured ever been to see, or been advised to see a surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, endocrinologist or other health care provider within the past 10 years? (Circle each provider and give details in the Additional Medical Information Section below.)

**ADDITIONAL MEDICAL INFORMATION** List below full details to questions answered "Yes." (Additional space available on the next page.)

| Question Number | Person Treated | Condition & Type of Treatment | Date Occurred | Last Date of Treatment | Current Status | Complete Name and Address of Physician |
|-----------------|----------------|-------------------------------|---------------|------------------------|----------------|--|
|                 |                |                               |               |                        |                |  |
|                 |                |                               |               |                        |                |  |
|                 |                |                               |               |                        |                |  |
|                 |                |                               |               |                        |                |  |

- Yes**  **No** In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? if "yes", list full details below. (Additional spaces available on the next page.)
- Yes**  **No** Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Additional space available on the next page.)

**PRESCRIPTION INFORMATION**

| Person Treated | Name of Drug | Dosage | Condition or Illness | Start Date | Stop Date | Complete Name and Address of Physician |
|----------------|--------------|--------|----------------------|------------|-----------|--|
|                |              |        |                      |            |           |  |
|                |              |        |                      |            |           |  |
|                |              |        |                      |            |           |  |
|                |              |        |                      |            |           |  |

