Individual Medical Questionnaire

WellNet

Employer Name _____

Employee Information

Last Name:_____ First Name:_____ MI:_____ Suffix:_____

Address Line 1:_____

Address Line 2:_____

City:_____ State:_____ Zip:_____

Email:_____ Phone:_____-_____-_____

Employment Status:

O Full Time Full Time Hire Date:_____ Hours per Week:_____

O Part Time Reason:_____

Marital Status:

O Single O Married O Divorced O Widowed

Independent Contractor:

O Yes O No

Intention to Enroll or Waive:

O Enroll O Waive

If enrolling, select coverage level:

O Employee O Employee/Spouse O Employee/Child(ren) O Family

Waiver Information

IF WAIVING COVERAGE, complete this section and sign the "Employee Agreement". All other sections should be left blank.

I waive coverage in the company's health plan for:

O Employee (Self) O Spouse O Child(ren)

Reason for Waiving Coverage:

O Other group/individual plan O Medicare O Medicaid O No Coverage O Other *(explain below)*

If other, explain:_____

If I have waived coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

Other Insurance Information

Do you or your dependents intend to keep other insurance coverage in addition to the one for which you are now applying?

O Yes O No

If yes, list family members who will be covered:_____

If yes, provide insurance company name(s) and policy number(s):_____

For any family members covered by Medicare, provide names and their effective date(s):_____

COBRA Information

Are you currently covered under COBRA OR currently in the COBRA election period?

O Yes O No Date of termination:_____ Number of months eligible:_____ Most recent month paid:_____

Individual Medical Questionnaire

Applicant Enrollment Information

The table should contain ALL family members applying for coverage

	Last Name	First Name	MI	Gender	DoB	Height	Weight	SSN
Employee								
Spouse								
Child								
Child								
Child								
Child								
Domestic Partner*								

**Coverage of Domestic Partners only applies if your employer provides such coverage. Employee may be required to provide evidence of Domestic Partner eligibility.*

Required Medical Information

Failure to provide complete responses for the "Required Medical Information" may result in a request for additional information and/or an inability to process your enrollment in the benefit plan.

1. Are you or any eligible dependent scheduled for or awaiting results of any tests, biopsies, procedures or lab work; or been advised to have a test?
   O Yes O No If yes, explain:_____
2. Have you or any eligible dependent been advised of a condition that will require attention in the next 24 months?
   O Yes O No If yes, explain:_____
3. Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier?
   O Yes O No If yes, explain:_____
4. Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care for any condition/surgery/procedure?
   O Yes O No If yes, explain:_____
5. Are you or any eligible dependent disabled?
   O Yes O No If yes, explain:_____
6. Are you or any eligible dependent hospital confined?
   O Yes O No If yes, explain:_____
7. Have you or any eligible dependent used tobacco products in the past twelve (12) months?
   O Yes O No
8. Are you or any eligible dependent pregnant? O Yes O No
   a. Name of pregnant person(s):_____; Due date(s):_____
   b. Expecting a multiple birth?
      O Yes O No
   c. Any history of fertility treatment?
      O Yes O No If yes, elaborate:_____
   d. Are there any known complications?
      O Yes O No If yes, elaborate:_____
   e. Is a C-Section planned?
      O Yes O No If yes, elaborate:_____
   f. Is the individual getting regular prenatal care?
      O Yes O No If yes, elaborate:_____
   g. Has the individual been tested for Group B Strep (not strep throat)?
      O Yes O No If yes, results:_____
   h. Has the individual had prior pregnancies? O Yes O No
      i. How many:_____
      ii. Delivery by: O C-Section OR O Vaginal delivery
      iii. Has the individual had any multiple gestations?
         O Yes O No If yes, explain:_____
      iv. Any issues with prior pregnancies?
         O Yes O No If yes, explain:_____
      v. Has the individual had any prior pregnancies end in fetal demise?
         O Yes O No If yes, explain:_____
   i. Does the individual smoke currently?
      O Yes O No
   j. Has the individual smoked in the past?
      O Yes O No If yes, when did the individual quit smoking?_____

Required Medical Information (continued)

9. In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for any of the following conditions:

Condition	Yes	No	Enrollee Name(s)	Treating Physician(s)	Diagnosis Date	Medication / Treatment / Surgery
AIDS/HIV/AIDS Related Complex						
Arthritis/Back/Joint Disorder						
Birth Defects/Congenital Disorder						
Breast Cancer						
Cancer/Tumor						
Diabetes						
Drug/Alcohol Abuse						
Heart/Blood/Vascular/ Hypertension						
Immune System Disorder						
Infertility						
Kidney Disorder						
Liver Disorder/Hepatitis						
Mental Disorder						
Neurological Disorder						
Organ/Tissue Transplants						
Respiratory/Lung Disorder						
Stroke						
Systemic Lupus/Multiple Sclerosis						

Employee Agreement

I affirm that I have reviewed all responses provided within this form about me and my dependents. Furthermore, I attest that they are true and correct to the best of my knowledge and that no material information has been withheld or omitted.

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of a Summary Plan Description. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor in the Summary Plan Description. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date. I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period. Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

I understand that information on this application is valid for a maximum of 90 days from the date of signature. To be a valid enrollment, your signature and date are required

Enrollee Signature:_____ Date:_____

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee:_____

Authorization to Release Medical Information for Enrollment

I hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand that I may request a copy of this authorization at any time. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 ½ years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand that I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

If waiving **ALL** coverage "Authorization to Release Medical Information for Enrollment" does NOT need to be signed.

Enrollee Signature:_____ Date:_____

If signed by a representative of enrollee, please indicate the representative's authority to act on behalf of enrollee:_____