HEALTH QUESTIONNAIRE FOR PURPOSES OF OBTAINING RATES FOR MMIA GROUP BENEFIT PLANS

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Employee

ENROLLING	WAIVING	Last Name First Name MI	Social Security Number (SSN) Your SSN may be included in your Subscriber Identification Number.	Date of Birth (mo | day | yr)	Male/ Female

Employee Mailing Address	City	State	ZIP Code	Daytime Telephone

Personal Care Physician (PCP) Name and City *(Required only for Managed Care Plans except Health First Direct)*	Marital Status ❑ Single ❑ Married* *Complete spouse's information below.	Date of Marriage (mo | day | yr)

Is the Employee covered under another health plan or agreement? ❑ Yes ❑ No
If yes, is the Employee covered under another health plan or agreement as a dependent spouse? ❑ Yes ❑ No

Spouse and Dependent(s)

ENROLLING	WAIVING	**All family members must be listed. Indicate for each family member whether enrolling or waiving coverage.** **Last Name First Name MI**	Social Security Number	Date of Birth (mo | day | yr)	Male/Female	Relationship	Personal Care Physician Name and City (Required only for Managed Care Plans except Health First Direct)

This section must be completed for all eligible Employees.

Other Coverage or Creditable Coverage

Have you or your dependents had health coverage within the last 63 days? ❑ Yes ❑ No
If yes, attach verification of creditable coverage to this form, OR complete the following information for you and your dependents.
Creditable coverage:

- **Including, but not limited to** Medicare, Medicaid, employer-based insurance, or an individual policy.
- **Does not include** limited benefit plans such as a cancer policy, a hospital indemnity plan, or a life insurance policy.

The coverage that you are applying for may have a 12-month waiting period for preexisting conditions. Credit toward fulfilling this waiting period is allowed based on health coverage you and/or your dependent(s) had during the past 12 months. In order to receive credit, an application for coverage must be received by MMIA within 63 days from the date of cancellation of the previous coverage.

Loss of eligibility: If you and/or your dependent(s) lost eligibility for coverage under another group plan, or if the employer of the other group plan stops contributing toward the premium, you and/or your dependent(s) may request coverage under your current group plan. This application must be received by MMIA within 31 days from the date the eligibility for the other group coverage ends. If you are applying due to a loss of eligibility, indicate that below for each member.

Name of Person Covered (Include last name if different from Employee)	Full Name, Address, and Telephone Number of Insurance Company or Carrier	Check Type of Coverage	Enrollment Date (mo | day | yr)	Cancel Date (mo | day | yr)	Will this coverage be continued?
Self: ID #*: Loss of eligibility ❑ Yes ❑ No		❑ Medical ❑ Dental			❑ Yes ❑ No
Spouse: ID #*: Loss of eligibility ❑ Yes ❑ No		❑ Medical ❑ Dental			❑ Yes ❑ No
Dependent: ID #*: Loss of eligibility ❑ Yes ❑ No		❑ Medical ❑ Dental			❑ Yes ❑ No

Dependent: ID #*: Loss of eligibility ❑ Yes ❑ No		❑ Medical ❑ Dental				❑ Yes ❑ No
*ID # is your identification number under previous or current insurance company or carrier.						

The following Health Questions must be answered by all eligible employees and participants.

If additional space is necessary to give complete information, use a separate sheet of paper, signed and dated.

Medical History

A. List current height and weight for all persons to be covered age 12 and older.

Name of Person	Current Height	Current Weight	Name of Person	Current Height	Current Weight

B. For any person to be covered age 15 and older, has there been a weight gain or loss of 10 or more pounds in the last 12 months?
❑ Yes ❑ No If yes, please provide date(s), name(s) of person(s), and detailed explanation(s).

C. Within the last three (3) years, have medications (except antibiotics) been prescribed for or been provided for (e.g., samples, injections) and/or been taken by any person to be covered? ❑ Yes ❑ No If yes, please explain below.

Name of Person	Name of Medication, Daily Dosage, and How Often Refilled	Condition for Which Medication Was Prescribed or Taken	Dates From (mo | day | yr)	Dates To (mo | day | yr)	Complete **Provider Name** (First and Last) **Address** City State ZIP Code

Medical History, (continued)

D. Does any family member whether applying for coverage or not, have reason to believe that they are an expectant mother or father (by positive result of a home pregnancy test, provider test, laboratory results, etc.)?
❑ Yes ❑ No If yes, name of person(s) and due date(s):
Explain any signs of complications:

E. Has any person to be covered EVER had or been diagnosed with any of the following?
❑ Yes ❑ No If yes, please explain below.

1. ❑ AIDS or AIDS-Related Complex
2. ❑ Cancer
3. ❑ Congenital Defect
4. ❑ Diabetes
5. ❑ Heart Murmur
6. ❑ Heart Problems
7. ❑ HIV Positive
8. ❑ Liver Disorder
9. ❑ Mental Disease or Disorder
10. ❑ Nervous System Disorder
11. ❑ Rheumatic Fever
12. ❑ Seizure Disorder/Epilepsy
13. ❑ Stroke or Circulatory Problems

Condition Number (1-13)	Name of Person	Diagnosis/Condition	Dates From (mo | day | yr)	Dates To (mo | day | yr)	Hospitalized?	Complete **Provider Name** (First and Last) or **Facility Name** **Address** City State ZIP Code
					❑ Yes ❑ No	
					❑ Yes ❑ No	
					❑ Yes ❑ No	

F. Has any person to be covered been diagnosed with, or treated or counseled for, any complaint, condition, illness, disorder, or disease relating to any of the following in the past five (5) years? ❑ Yes ❑ No If yes, please explain below.

14. ❑ Alcohol or Drug Use
15. ❑ Anxiety/Depression
16. ❑ Eating
17. ❑ Suicide Attempt
18. ❑ Attention Deficit Disorder (ADD)
19. ❑ Hyperactivity
20. ❑ Breasts
21. ❑ Back
22. ❑ Colon or Intestines
23. ❑ Joints
24. ❑ Kidneys
25. ❑ Lungs
26. ❑ Prostate
27. ❑ Reproductive Organs
28. ❑ Thyroid
29. ❑ Urinary Tract
30. ❑ Allergy
31. ❑ Arthritis
32. ❑ Asthma
33. ❑ Digestive
34. ❑ Fracture
35. ❑ GERD
36. ❑ Headaches/Migraines
37. ❑ Hernia
38. ❑ High Blood Pressure **(Complete Blood Pressure Table below)**
39. ❑ Infertility
40. ❑ Ulcer

Condition Number (14-40)	Name of Person	Diagnosis/Condition	Dates From (mo | day | yr)	Dates To (mo | day | yr)	Hospitalized?	Complete **Provider Name** (First and Last) or **Facility Name** **Address** City State ZIP Code
					❑ Yes ❑ No	

					❑ Yes ❑ No	
					❑ Yes ❑ No	

G. Has any person to be covered received or been recommended to receive any medical treatment that has not been listed above? This includes counseling, follow-up for abnormal laboratory results, examinations/tests, or care recommended by physicians, other medical practitioners, or a legal authority.

❑ Yes ❑ No If yes, please indicate whether the treatment has been received or recommended, and provide date(s), name(s) of person(s), and detailed explanation(s).

H. Has any person to be covered been fitted with any implants or orthopedic device (including pins, screws, plates, or braces) or does any person regularly use durable medical equipment (e.g., a wheelchair, splints, or crutches)?

❑ Yes ❑ No If yes, please provide date(s), name(s) of person(s), and detailed explanation(s). Also, note whether orthopedic devices are temporary or permanent.

Must be completed if answered "Yes" to # 38 above. (Give the three most recent readings, at least one month apart)

Blood Pressure

Name of Person	Date Taken/ Blood Pressure Reading	Date Taken/ Blood Pressure Reading	Date Taken/ Blood Pressure Reading

Conditions of Enrollment

I/We hereby apply for coverage with MMIA. I/We certify and understand the following:

1. I/We personally completed the Medical History section (if required) of this form, filling in all requested information.
2. All of the statements made are true and complete for me and for each person included on this statement.
3. This is a health questionnaire only and does not guarantee issuance of coverage. The information contained herein will be used for purposes of determining group health rates.

Signature(s)

I

Must also have signature(s) of spouse and/or all dependent(s) age 18 and over if applying.

Signature(s) DO NOT PRINT	Signature Date (mo | day | yr)	Signature(s) DO NOT PRINT	Signature Date (mo | day | yr)
Employee		Spouse	
Dependent		Dependent	
Dependent		Dependent	