



Health Questionnaire

Instructions:

You, the employee, must complete this health questionnaire in full for you and any dependents to be enrolled or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.

Note:

This questionnaire is not required if you are declining coverage.

Employer Information

Name			
Address	City	State	Zip

Employee Information

Last Name, First Name, M.I.		Social Security Number	
Address	City	State	Zip

Information – Employee, Spouse and Other Dependents

Name (Last, First, M.I.)	Sex	Social Security Number	Birthdate	Height (ft. in.)	Weight

Health History for Individuals and Their Dependents

- ALL of the questions must be answered by you and your dependents or the application will be returned.
- Incomplete applications may delay the effective date of your coverage.

In the past five (5) years, has any person listed on the application seen a health care provider(s), had treatment recommended, received treatment, including prescription medications or been hospitalized for any of the following conditions listed below?

	Yes	No
1. Heart attack, heart murmur, stroke, chest pain, high blood pressure, anemia, varicose veins or other disorders of the heart, blood, blood vessels or high cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>
2. Ulcer, colitis, gallstones or any other disorder of the stomach, intestines, rectum, pancreas, liver or Hepatitis B/C?	<input type="checkbox"/>	<input type="checkbox"/>
3. Cancer, cyst or tumor?	<input type="checkbox"/>	<input type="checkbox"/>
If cancer, please indicate what stage (<i>if known</i>) _____ .		
4. Disorders of the kidneys, adrenal glands, thyroid glands, urinary systems, male or female organs, infertility, menstrual dysfunction or sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Asthma, emphysema, tuberculosis or any other disorders of the lungs or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
6. Migraines, fainting spells, epilepsy, mental or nervous conditions, depression, paralysis or any disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
If epileptic, date of last seizure: ___ / ___ / ___ (month/day/year)		

The statements made by you in this questionnaire will be relied upon to determine group rates for any plan(s) offered to your employer by Aetna Health Inc., and/or Aetna Health of Illinois Inc., and/or Corporate Health Insurance Company and/or Aetna Life Insurance Company (collectively "Aetna"). For groups not subject to guaranteed issue rules, the information may also be used to determine if any plan(s) will be offered to your employer.

Employee Name (Last, First Name, M.I.)	Employer Name
--	---------------

Health History for Individuals and Their Dependents (Continued)

	Yes	No
7. Lupus, arthritis, back trouble or any other disorder of the joints, muscles or bones, including prosthetic device or implants?	<input type="checkbox"/>	<input type="checkbox"/>
8. Any physical deformity, defect or congenital problem?.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Has any person to be covered had or has been told that they have an immune disorder, AIDS or AIDS related complex?	<input type="checkbox"/>	<input type="checkbox"/>
10. Has any person been treated for alcoholism, other drug or substance abuse, including use of any illegal or controlled drugs, or been advised to seek treatment for the same?.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Has any person been diagnosed with diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list date of diagnosis: ___/___/___ (month/day/year)		
Insulin dependent? _____ Non-insulin dependent? _____		
12. a. Is any female to be covered currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, list due date: ___/___/___ (month/day/year)		
b. Have there been any complications thus far?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are multiple births expected?	<input type="checkbox"/>	<input type="checkbox"/>
d. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on this application?.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Has any applicant taken any prescribed medications in the past 12 months? If yes, list below.	<input type="checkbox"/>	<input type="checkbox"/>
14. Has any applicant had an abnormal physical exam or been advised to undergo further testing, surgery or treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>
15. Has any applicant been a patient in a hospital, clinic, surgical center, sanatorium or medical facility as an outpatient or inpatient (excluding childbirth)?	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anyone named on this application use tobacco products, including cigarette, pipe, cigar, or chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
17. Has any applicant been diagnosed and/or treated for any medical condition or symptom not listed on this application?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE THE INFORMATION BELOW.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked above. In addition, please give details below of last doctor visit and/or physical examination for ALL family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Ques. #: [] Name of Applicant: _____ Date of Onset: Month ____ / Year ____ Still under Treatment: Yes <input type="checkbox"/> No <input type="checkbox"/> Medication: _____ Dosage: _____ Treatment Given: _____	Name of Illness/Condition: _____ Date Treatment Ended: Month ____ / Year ____ Date Prescribed: Month ____ / Year ____
--	--

Ques. #: [] Name of Applicant: _____ Date of Onset: Month ____ / Year ____ Still under Treatment: Yes <input type="checkbox"/> No <input type="checkbox"/> Medication: _____ Dosage: _____ Treatment Given: _____	Name of Illness/Condition: _____ Date Treatment Ended: Month ____ / Year ____ Date Prescribed: Month ____ / Year ____
--	--

Ques. #: [] Name of Applicant: _____ Date of Onset: Month ____ / Year ____ Still under Treatment: Yes <input type="checkbox"/> No <input type="checkbox"/> Medication: _____ Dosage: _____ Treatment Given: _____	Name of Illness/Condition: _____ Date Treatment Ended: Month ____ / Year ____ Date Prescribed: Month ____ / Year ____
--	--

Employee Name (Last, First Name, M.I.)	Employer Name
--	---------------

Certification

I represent that these answers and statements are complete and true to the best of my knowledge and belief. I acknowledge that I have been given a copy of this document a completed by me. I understand that the information provided will not affect my eligibility to participate in this plan. I understand that if at any time it is determined by Aetna that a person listed on this questionnaire did not meet the plan's definition of employee or dependent, Aetna and/or its subsidiaries have the right to terminate or rescind coverage for that person or for all ineligible persons under the questionnaire, and to recover any benefit payments made for such ineligible person or persons.

Employee Signature	Date (Mo/Day/Year)
Spouse Signature	Date (Mo/Day/Year)