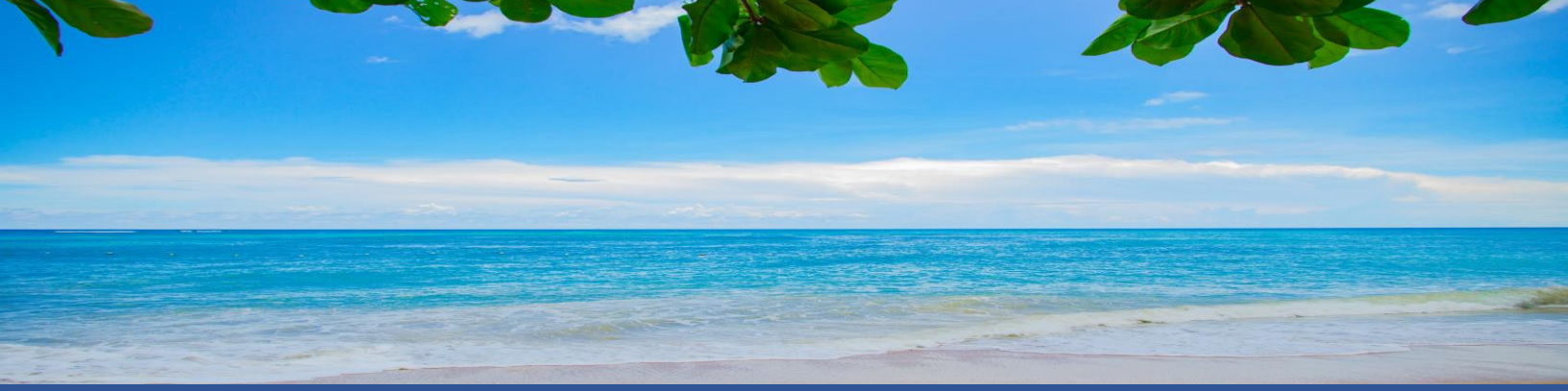

Health Insurance Questionnaire

Requested Effective Date: _____/_____/_____

Primary Applicant					
Name:			□ Male □ Female	Applying For Coverage? Y / N	
DOB:	Phone:			US Citizen? Y / N ↳ If no, Legal Immigrant? Y / N	
Email:				Lived in US for previous 12 months? Y / N	
Employer Name:				Tobacco User? Y / N	
20+ Employees? Y / N	Employer Phone:			Annual Income:	

Spouse					
Name:			□ Male □ Female	Applying For Coverage? Y / N	
DOB:	Phone:			US Citizen? Y / N ↳ If no, Legal Immigrant? Y / N	
Email:				Lived in US for previous 12 months? Y / N	
Employer Name:				Tobacco User? Y / N	
20+ Employees? Y / N	Employer Phone:			Annual Income:	

Dependent(s)					
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N

Care Providers		
Facility:	Doctor:	□ Physician □ Specialist □ Hospital
Facility:	Doctor:	□ Physician □ Specialist □ Hospital
Facility:	Doctor:	□ Physician □ Specialist □ Hospital
Facility:	Doctor:	□ Physician □ Specialist □ Hospital

Medications			
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days

Additional Information Worksheet

Additional Dependent(s)

Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N
Name:	□ Male □ Female	DOB:	Smoker? Y / N	Annual Income:	Applying? Y / N

Additional Care Providers

Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital
Facility:	Doctor:	□ Physician	□ Specialist	□ Hospital

Additional Medications

Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days
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Prescription:	Dosage:	Refill Amt:	Refill Freq: □ 30 Days □ 60 Days □ 90 Days