Group Medical Questionnaire

Medical Profile

Plan Sponsor: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than $10,000 been paid in the last 12 months? _____ Yes _____ No

B. Within the past 12 months, has any employee or dependent had a continuing claim (i.e., chronic or ongoing condition) due to a mental or physical disorder? _____ Yes _____ No If "Yes," check the appropriate space(es) below.

_____AIDS/Immune Disorders _____Cardiovascular _____Infertility _____Neurological
_____Alcohol Abuse _____Diabetes _____Intestines _____Pancreas
_____Arthritis _____Drug/Substance Abuse _____Kidney _____Skin
_____Back/Neck _____Epilepsy _____Liver _____Stomach
_____Blood _____Ears/Eyes _____Lungs _____Stroke/Paralysis
_____Bone/Joint _____Emphysema/Pulmonary _____Lupus
_____Venereal
_____Brain _____Heart Disease _____Mental/Nervous _____Other, Detail Below
_____Cancer/Tumor _____High Risk Pregnancies _____Migraines

C. Are any employees or dependents pregnant? _____ Yes _____ No If "Yes," how many? _______
Any high risk pregnancies? _____ Yes _____ No If "Yes," how many? _______
Any multiple births expected? _____ Yes _____ No If "Yes," how many? _______

If you answered "Yes" to question A or B, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	$ Amount of Prior Claims	Prognosis/Current Treatment

The information on this form is designed to assist in the evaluation of your group. The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please Print)	Prospective Applicant Signature	Date
Agent Signature (Existing _____Yes _____No) Date	Sales Representative Signature	Date