

SMALL BUSINESS GROUP

HEALTH QUESTIONNAIRE

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This health statement is part of the application for coverage and applies to the employee and all dependents enrolling. All parts must be completed and returned to us with your application. Statements with incomplete or illegible information may have a negative impact on your group’s premium.

I. Employer Data—Complete with the name of your employer/company offering benefits

Name of Employer _____

II. Employee/Dependent Information (Attach separate sheet if necessary)

Name (First, M.I., Last)	Relationship to employee	Birthdate MM/DD/YY	Sex M/F	Height (In feet and inches)	Weight (In pounds)
	Self				

III. Your Medical Information—Please provide details, in Section IV, to all checked conditions

ALL QUESTIONS, UNLESS OTHERWISE INDICATED, ARE LIMITED TO THE MOST RECENT 5 YEARS.

Please check all that apply to yourself, spouse, and any listed dependent(s):

1. Have you or any listed dependent(s) ever been diagnosed with, consulted or treated for any of the following:

- | | Self | Spouse | Dep | |
|----|--------------------------|--------------------------|--------------------------|---|
| A. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | AIDS, HIV, lupus, or other immune system disorders? |
| B. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Alcohol or drug abuse? |
| C. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma, emphysema, recurring bronchitis, or any other lung conditions? |
| D. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back conditions, bone or spinal diseases including arthritis? |
| E. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Brain or nervous system disorders including Parkinson’s disease? |
| F. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer, and/or cancerous tumor? (state type and body part in Section IV) |
| G. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cirrhosis, hepatitis, or any other liver condition? |
| H. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes or thyroid disease, or enlargement of lymph nodes? (state type in Section IV) |
| I. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ear disorders? |
| J. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy, convulsions, seizures, fainting, or vertigo? |
| K. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Eye disorders or cataracts? |
| L. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gallbladder disorders? |
| M. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart disease, high blood pressure, or any other cardiovascular disorders? (state blood pressure reading, including date and results in Section IV) |
| N. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High cholesterol? (state whether mild, moderate, or severe in Section IV) |
| O. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Infertility, sterility, or other reproductive disorders? |
| P. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney, bladder, or other urinary conditions? |
| Q. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Low blood sugar or elevated blood sugars? |

III. Your Medical Information (continued)—Please provide details, in Section IV, to all checked conditions

Please check all that apply to yourself, spouse, and any listed dependent(s):

1. (continued) Have you or any listed dependent(s) ever been diagnosed with, consulted or treated for any of the following:

- | | Self | Spouse | Dep | |
|----|--------------------------|--------------------------|--------------------------|---|
| R. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Multiple sclerosis? |
| S. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Nervous or mental disorders, including anxiety, depression, or eating disorders such as anorexia or bulimia? |
| T. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Organ transplant or discussed possible future transplant? |
| U. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke or TIA? |
| V. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers, esophagitis, gerd, or any other digestive or stomach disorder?
(state frequency of attacks in Section IV) |
| W. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Within the past five (5) years, has any person listed above had any symptoms of, or received medical or surgical advice or treatment for any serious, chronic condition, or injury other than what is mentioned above? |

Please check all that apply to yourself, spouse, and any listed dependent(s):

- | | Self | Spouse | Dep | |
|----|--------------------------|--------------------------|--------------------------|--|
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, or currently hospitalized? (provide details in Section IV) |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Had unexplained weight loss or fatigue in the past 12 months? |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Use or used alcohol or unprescribed drugs?
(state type, quantity and frequency in Section IV) |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Use or used tobacco in any form? (state type, quantity and frequency in Section IV) |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Currently pregnant? |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are there multiple births, or any other complications such as delivery by Cesarean expected? (provide details in Section IV) |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Taken any prescription drugs in the last five (5) years?
Please list medications below: |

Family member	Medication/dosage	Condition used for	Date started	Date ended	Currently taking?

IV. Medical Information Detail Section—Please provide details to any checked answers from section III

If you checked any question in Section III, please provide details by stating specifics under each column heading. Please be sure all columns are completed for each condition. Indicate the question's number and/or letter for which you are providing details. Use additional sheets if necessary. Sign and date any attached pages.

Number and letter	Patient	Dates of treatment (from/to)	Condition AND diagnosis	Type of treatment and prognosis	On-going? (Y/N)

Authorization To Review Existing Information

1. I hereby authorize Kaiser Foundation Health Plan of Colorado to review any existing Kaiser Permanente medical records and history of care provided to me or my dependents as members of Kaiser Foundation Health Plan for a period of up to 5 years preceding submission of this questionnaire. This authorization applies to all types of care including diagnosis and treatment of mental health, alcohol/chemical dependency, HIV, AIDS, or AIDS-related condition, and is limited to information reasonably related to determining health risk for rating purposes. I understand that Kaiser Foundation Health Plan will not redisclose any information received through this review except with my written consent or as permitted by federal and/or state laws and regulations. This authorization for review is effective during all times that my/our application and/or rating status are being considered. I authorize Kaiser Foundation Health Plan, without limitation and including all categories of care stated above, to review my Kaiser Permanente medical records, including pharmacy records, for a period of up to 12 months following my/our actual enrollment and initial usage of services in order to confirm consistency with the information I submitted in this application.

2. Insurance Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to any insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and possible civil damages. Any insurance company or agent or an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signature of employee	Date	Signature of spouse	Date
Signature of other adult/emancipated dependent	Date	Signature of other adult/emancipated dependent	Date

I hereby certify that the answers on this form were completed or furnished by me on behalf of the applicant and are true to the best of my knowledge.

Signature of applicant or guardian, if applicant is a minor	Date
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***This health questionnaire must be updated to include any change in health status, impairment, or disease that occurs between the date of application and the effective date. Failure to provide this information to Kaiser Permanente will constitute a misrepresentation to the presence of a pre-existing condition or disease.**