Employee Name:	Employer Name:

- ☐ Currently enrolled in group health plan
- ☐ Currently not enrolled in group health plan
- ☐ May enroll in group health plan

MEDICAL INFORMATION

You are NOT required to share this information with your employer. This form must be completed, return this completed form in a sealed envelope to your employer or send by confidential fax to 720-367-5162. If sending by sealed envelope, please write your name and CONFIDENTIAL on the outside of the envelope for easy identification.

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this questionnaire is signed is the date which you should use when answering questions that request you to provide prior history for a period of time.

This health questionnaire must be updated to include any change in health status that occurs between the date of application and the effective date.

A. Are you, your spouse or any dependent children currently pregnant or an expectant parent? ☐ Yes ☐ No
   If yes, please indicate due date: Twins or other multiple(s) expected? ☐ Yes ☐ No
   Complications? ☐ Yes ☐ No C-Section Expected? ☐ Yes ☐ No

B. In the past 5 years, has anyone considering coverage been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

C. Has anyone considering coverage used tobacco products during the past 12 months? ☐ Yes ☐ No
   If yes, please complete the following:
   Name(s): _____ ☐ Cigarettes ☐ Chewing tobacco ☐ Pipe/Cigars
   Duration: _____ Frequency: _____

D. In the past 5 years, has anyone considering coverage been evaluated or treated for alcoholism or chemical dependency, or joined any organization for alcoholism or chemical dependency; or used illegal drugs; or been advised by a health care professional to reduce the use of alcohol or illegal drugs? ☐ Yes ☐ No

E. In the past 5 years, has anyone considering coverage sustained an injury as a result of an auto or work related accident? ☐ Yes ☐ No

Within the past 5 years, has anyone considering coverage been counseled, or consulted or treated for any of the following: ☐ Yes ☐ No

1. Heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, anemia or blood disorder, elevated cholesterol and/or triglyceride levels or any other circulatory system issue? ☐ Yes ☐ No
2. Ulcers, stomach disorder, liver/pancreas disorder, hernia, gallbladder disorder, rectal disorder, intestine disorder, esophageal disorder, hepatitis, colitis, Crohn's disease or other digestive system issue? ☐ Yes ☐ No
3. Urinary tract/kidney/bladder disorder, prostate disorder, renal failure, menstrual disorder, genital disorder, sexual dysfunction, infertility, dialysis, sexually transmitted disease, pregnancy complications (e.g., premature birth, miscarriage, C-Section), breast disorder or other genitourinary system issue? ☐ Yes ☐ No
4. Connective tissue disorder, thyroid disorder, adrenal disorder, diabetes, enlargement of the lymph-nodes, lymph system disorder, pituitary disorder, any growth disorder or other endocrine system issue? ☐ Yes ☐ No
5. Allergy(ies), asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath, sleep apnea or other respiratory system issue? ☐ Yes ☐ No
6. Arthritis, fibromyalgia, back/neck disorder, joint/bone disorder, knee disorder, carpal tunnel, skin disorder, chronic fatigue syndrome or other musculoskeletal issue? ☐ Yes ☐ No
7. Brain disorder, aneurysm, paralysis, central nervous system disorder, cerebral palsy, epilepsy or other seizures, headaches, multiple sclerosis or other nervous system issue? ☐ Yes ☐ No
8. Cancer, tumor, abnormal growth, cyst or carcinoma-in-situ? ☐ Yes ☐ No

9. Eye or ear disorder? ☐ Yes ☐ No
10. Attention deficit disorder, psychological disorder, suicide attempt, depression, anxiety, autism or other behavioral health issue or biologically based mental illness (schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder)? ☐ Yes ☐ No
11. Organ or other type of transplant or implant (including breast implants), gastric bypass, physical deformity or defect including cleft lip or cleft palate, prosthetic device, congenial disorder, down's syndrome? ☐ Yes ☐ No
12. Within the past 5 years, has anyone considering coverage had any other injury, illness or treatment for any condition not already listed, been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application. *We are **NOT** seeking the results of HIV Antibody Test.* ☐ Yes ☐ No

If you answered "Yes" to any of the questions or conditions above, please list and provide the complete details in the space provided below.
(Attach additional pages as needed. Please print your name and sign the additional pages.)

Name of Person	Date(s) of Treatment	Question Number	Give full details for each question answered "yes", state the condition, duration and degree of recovery. If accident or injury, also indicate if auto or work related.	Name and address of attending physician or other health care provider.

If anyone considering coverage is taking medication or was prescribed or recommended any medication during the period of time related to your answer (i.e. past 5 years or currently taking), please list all of those medications, dosages, and what the medical condition is being treated or were treated by each medication in the space provided below.
(Attach additional pages as needed. Please print your name and sign the additional pages.)

Name of Person	Name, dosage and frequency of medication (include illness or health condition for which medication was prescribed)	Date(s) medication taken (indicate if ongoing)	Name and address of prescribing physician or licensed health care provider

I understand and agree that any information obtained in connection with this form will be used to determine eligibility for coverage, underwriting, and for purpose of analysis to develop more efficient health care management techniques for the Health Plan. I understand that this information will be securely provided to the carrier's agent/underwriter.

Misrepresentation
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the 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.

Employee Signature

I certify that all information supplied in this form is true and complete to the best of my knowledge and/or belief.	Employee Signature – Required X	
	Date / /	Email Address