



CHA Health INDIVIDUAL MEDICAL QUESTIONNAIRE

Group Name: _____						
Name (Last, First, Middle Initial)	Date of Birth (Mo/Day/Year)	Age	HT	WT	Gender	Full Time Student Y/N*
Employee						
Spouse						
Child 1						
Child 2						
Child 3						
Child 4						
Date of Full-Time Hire: _____		*Verification of Full-Time Student Status required for Ages 19-24. Submit with Application				
Number of hours worked/week _____		Status: <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> Cobra				

HEALTH INFORMATION - Explain any "YES" answers in complete detail. Use back of document and extra paper if necessary.

- Yes No 1. Have you or any of your dependent(s) visited a health care professional in the last 7 years for any illness, injuries, or medical conditions resulting in claims in excess of \$5,000 (including mental health and chemical dependency)? **If yes, list person's name, dates, attending physician(s) reason for treatment and result of visit(s).**
- Yes No 2. Have you or any of your dependent(s) had any hospitalizations (including inpatient and outpatient) in the last 7 years, or been advised of having any medical conditions? **If yes, list person's name, dates, attending physician(s) and reason hospitalized or treated. (Including mental health and chemical dependency).**
- Yes No 3. Have you or any of your dependent(s) taken any prescription medications in the last 24 months? **If yes, list person's name, name of drug, dosage, prescribing physician, condition medication prescribed for and dates taken.**
- Yes No 4. Are you or any dependent(s) aware of any condition, illness or injury which may require ongoing treatment or future surgery or treatment of any type or has any surgery or treatment been recommended that has not yet been performed? **If yes, list person's name, type of surgery or treatment and dates.**
- Yes No 5. Are you or your spouse currently pregnant? **If yes, list person's and expected delivery date.**
- Yes No 6. Has any person for whom coverage is being requested applied for disability or had any condition covered by worker's compensation? **If yes, list person's name and disability or condition.**

I hereby authorize any hospital, physician, surgeon, or pharmacist to release any information requested by CHA Health with respect to any claim of the delivery of medical care received during the past seven years on behalf of myself or a covered dependent. A photocopy of this authorization will serve the same as an original.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or concealed, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime.

SIGNATURE This form must be signed)

Employee Name: _____ (Please Print) Employee Signature: _____ Date