

INDIVIDUAL HEALTH QUESTIONNAIRE AND MEDICAL HISTORY STATEMENT
MUST BE COMPLETED BY THE SUBSCRIBER ON BEHALF OF DEPENDENTS APPLYING FOR
COVERAGE EACH CONDITION MUST BE MARKED "YES" OR "NO"
INCOMPLETE HEALTH INFORMATION WILL BE RETURNED

Subscriber's Name: _____ ID # _____ Children's Name(s) _____ Relationship _____ Height _____ Weight _____
 Spouse's Name: _____ Height: _____ Weight: _____

Are there any other family members who are not currently enrolled or presently applying? If yes, explain:

	Yes		No			Yes		No			Yes		No		
Have any listed Family Members EVER experienced problems with, been diagnosed with, or been treated for any of the following:					20. Mental Retardation					39. Digestive System					
1. AIDS/HIV positive					21. Neurological Disease					40. Drug Abuse/Addiction					
2. Amputation					22. Paralysis					41. Eyes, Ears, Nose, Throat					
3. Arteries/Veins					23. Polio (late effect)					42. Female or Menstrual Problems					
4. Arthritis or Rheumatism					24. Suicide (attempted)					43. Foot Problems					
5. Autism					25. Stroke/Brain					44. Fracture or Dislocation					
6. Back/Neck Surgery					26. Tumor or Growth (include location)					45. Gall Bladder/Gall Stones					
7. Birth Defects					Within the LAST FIVE YEARS have any listed Family Members experienced problems with, been diagnosed with, or been treated for any of the following:						46. Glandular/Hormone System				
8. Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc(s), spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, or spondylosis					27. Abnormal Pap Test					47. Gout					
9. Blood Disease or Problems					28. Abnormal PSA (Prostate Specific Antigen)					48. Hemorrhoids/Rectal Problems/ Polyps					
10. Bowel Disorder/Colitis					29. Accidental Injuries					49. Hernia					
11. Cancer					30. Alcoholism					50. High Blood Pressure					
12. Congenital Disorders/Defects					31. Allergies/Hay Fever					51. Infertility					
13. Diabetes					32. Asthma					52. Irritable Bowel Syndrome					
14. Endometriosis					33. Bladder/Urinary Disorder					53. Kidney Disorder/Nephritis					
15. Epilepsy, Seizure, or Convulsions					34. Bone/Joint					54. Kidney Stones					
16. Heart Disease or Problems					35. Back, neck, or spinal problems that required medical attention and/or interfered with normal daily activities.					55. Knee Problems					
17. Liver disease/Cirrhosis					36. Breast Disorder					56. Migraines/Headaches or Dizziness					
18. Lung Disease/Tuberculosis					37. Jaw Problems					57. Mental Illness					
19. Lupus					38. Depression/Chemical Imbalance					58. Muscular/Nervous System					
										59. Pain (intractable or uncontrollable)					
										60. Pregnancy (complications of)					
										61. Premature Birth(s) (include gestational age & birth weight)					
										62. Prostate Disorder/Male Organs/ Impotence					
										63. Sexually Transmitted Disease					

	Yes	No		Yes	No		Yes	No	
64. Sinus Disorder			72. In the past 5 years has any listed Family Member experienced any condition for which future consultation, treatment or surgery is contemplated or advised?			76. Has any listed Family Member consulted a physician in the last 12 months? Give date(s) and reason(s). Complete the following questions for all immediate family members whether or not proposed for insurance.			
65. Skin Disorder									
66. Stomach/Intestine Disorder									
67. Surgical Operation(s)									
68. Thyroid Disorder or Goiter									
69. Ulcers									
70. Varicose Veins			73. Does any listed Family Member smoke now or has smoked in the past? If "yes," please specify who smoked, for how long, and when individual quit (if applicable).			77. Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period?			
Complete the following questions for all family members proposed for insurance.									
71. Does any listed Family Member have any serious medical problems, or deformities not listed?			74. Has any listed Family Member received any treatments or tests within the last 12 months?			78. Are you, your spouse or any eligible child (whether or not proposed for insurance) currently pregnant?			
			75. Has any listed Family Member received any medications, injections or drugs within the last 12 months?			79. Is anyone currently pregnant with your child, or your spouse's child?			

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS OR CONDITIONS LISTED, PLEASE PROVIDE AN EXPLANATION BELOW - attach additional pages as needed

Question #	Name	Describe in detail each of the following that applies: (1) Nature of Condition, (2) symptoms, (3) type of surgery, test, treatment, consultations, or medications (including dosages) received or contemplated, and (4) degree of recovery	Physician Name	Dates of Care Mo/Yr
				From To
				From To
				From To

Has any insurance company (including Regence BlueCross BlueShield of Utah) refused, up-rated or restricted any health coverage on any family member?

Explain: _____

I certify that, in preparation for my responses to this health questionnaire, I have familiarized myself with the health history of my dependents, that the above information is true, correct, and complete to the best of my knowledge, and I acknowledge that any coverage issued by the Plan will be issued in reliance thereon. Should any information called for or provided by me in this questionnaire, by or on behalf of me or my dependents, prove untrue, inaccurate, or incomplete, the Plan shall have the right to declare my contract null and void in accordance with applicable provisions of Utah state law, or the Plan, at its option, shall have the right to exclude or deny coverage for any claim, condition, or family member related in any way to such untrue, inaccurate, or incomplete information. I hereby authorize any health care professional or other person or entity to release to the Plan any record, document, or other information in connection with any inquiry or investigation into the truth, accuracy, or completeness of the information I have provided herein. I agree to execute requested releases for medical and other records to be released to the Plan and agree that the Plan may cancel my coverage retroactive to its original effective date if I refuse or decline to provide such a release within thirty (30) days after it is requested by the Plan. I understand and agree that the Plan may require me to provide evidence of insurability at my own expense. I further understand and agree that this and all other documents submitted by me remain the exclusive property of the Plan.

Subscriber's Signature _____ Date _____ Spouse's Signature _____ Date _____