RISK EVALUATION FORM

Section A:

Group Name: _____ Date Completed: _____

Group Address: _____ Effective Date Requested: _____

_____ Completed By: _____

_____ (Title): _____

Section B:

	Yes	No
Has any employee or dependent:		
1. Had problems or been treated for any of the following? *(Circle all that apply and explain below).* Alcoholism/Drug Addiction, Arthritis, Birth Defects, Blood, Cancer, Diabetes, Digestive System/ Colitis, Heart, Infertility, Kidney/Urinary, Liver, Lung, Mental/Emotional, Nervous System/Muscular, Sexually Transmitted Disease/AIDS, or Stroke/Brain?	☐	☐
2. Experienced any other serious deformities, symptoms or problems not listed above or is aware of any such conditions existing?	☐	☐
3. Incurred medical expenses of $5,000 or more, or is anticipating such medical costs now or in the future?	☐	☐
4. Been prevented by disability or other health condition from performing usual job activities on more than four occasions or for a total of more than two weeks?	☐	☐
5. Received or anticipate receiving any kind of transplant?	☐	☐

Section C:

For any item in **Section B** checked "Yes", complete the following:

List Item#	List Applicant's or Dependent's Name, Age and Sex	List Problem, Treatment and Degree of Recovery	Dates of Care First / Last	Cost of Care
			/	
			/	
			/	
			/	
			/	
			/	

Section D:

List any Applicant or Dependent who is currently pregnant:

List Applicant's or Dependent's Name *(First, Last)*	List Any Known or Anticipated Abnormalities *(i.e., Twins, Premature Birth, C-Section, Etc.)*	List Age	List Due Date *(MM / YY)*

IF ADDITIONAL SPACE IS REQUIRED, USE REVERSE SIDE

I/We certify to the best of my/our knowledge that the above information is true, complete and accurate, and acknowledge that Regence BlueCross BlueShield of Utah, an independent licensee of the BlueCross and BlueShield Association, will issue coverage in reliance thereon.

_____ _____ _____ _____

Signature (Group Official) Date Signature (Agent/Agency) Date