



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

SHORT FORM HEALTH QUESTIONNAIRE AND MEDICAL HISTORY STATEMENT (Groups 51+)

MUST BE COMPLETED AND EXECUTED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS INCLUDING ANY WHO ARE DECLINING COVERAGE

Section A

| | | | | | |
|--|---------------------------------|--------------------------|--------------------------------|--------------------------|----|
| Name of Employer's Group _____ | | YES | NO | YES | NO |
| Employee's Name _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| Spouse's Name _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| Dependent Children's Names _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |
| _____ Date of Birth _____ Sex _____ | Enroll <input type="checkbox"/> | <input type="checkbox"/> | Waive <input type="checkbox"/> | <input type="checkbox"/> | |

Section B

| | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| 1. Have you or any family member ever had, been told you had, consulted a health care professional for, or received counseling or treatment for: | | |
| a) conditions, disorders, diseases, or problems of or affecting the heart, immune system, kidney, liver, lungs, muscular system, nervous system and/or pancreas? | <input type="checkbox"/> | <input type="checkbox"/> |
| (Circle all that apply and explain below.) | | |
| b) alcohol or drug dependency, cancer, ulcerative colitis, congenital disorders, diabetes, leukemia, lupus, severe mental illness, sexually transmitted disease/AIDS and/or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| (Circle all that apply and explain below.) | | |
| c) any serious condition, disorder, disease or problem not listed above or are aware of such a condition existing? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any family member currently taking medications which exceed the cost of \$500 per month? . . | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you or any family member ever incurred medical expenses of \$5,000 or more in any twelve-month period, or are such medical costs anticipated now or in the future? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any family member currently pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| (If yes, please explain below any anticipated problems and provide due date.) | | |

Section C

For any question in Section B answered **Yes**, complete the following:

| Question # | Employee or Family Member Name, Age and Sex | List condition, disorder, disease, problem, treatment and degree of recovery | Dates of Care First/Last (Due Date if Pregnant) | Actual or Expected Cost of Care |
|------------|---|--|---|---------------------------------|
| | | | | |
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IF ADDITIONAL SPACE IS REQUIRED, USE REVERSE SIDE

I certify 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 provided by me in this questionnaire prove untrue, inaccurate, or incomplete, the Plan shall have the right to declare my contract null and void and to deny any claims incurred. I hereby authorize any health care provider to release to the Plan any medical records, documents or other medical information pertaining to my health or the health of my family members. I understand and agree that the Plan may require me to provide evidence of insurability at my own expense and that this and all other documents provided by me remain the exclusive property of the Plan.

Employee Signature _____

Date Signed _____