CONSOLIDATED BENEFITS
An Employer's Best Friend

CONSOLIDATED BENEFITS AGENCY, INC.
APPLICANT MEDICAL HISTORY QUESTIONNAIRE

EMPLOYEE NAME			SOCIAL SECURITY NO.
ADDRESS NUMBER & STREET	CITY	STATE	ZIP CODE
HOME PHONE# ( )	WORK PHONE# ( )		EXT.
EMPLOYER NAME			OCCUPATION

TYPE OF COVERAGE SELECTED: (CHECK ONE) ☐FOR YOU ONLY ☐FOR YOU PLUS 1 DEPENDENT (SPOUSE OR CHILDREN) ☐FOR YOU PLUS 2 OR MORE DEPENDENTS

COMPLETE THE FOLLOWING INFORMATION FOR ALL PERSONS (APPLICANTS) TO BE COVERED, INCLUDING YOURSELF.

NAMES last	first	mi	RELATIONSHIP	DATE OF BIRTH mo/day/yr	SEX	HEIGHT	WEIGHT
Employee							
Spouse							
Dependents							

COMPLETE THE FOLLOWING QUESTIONS FOR ALL PERSONS TO BE COVERED:
(For purposes of the following medical questions, the term "medical or social practitioner" includes but is not limited to: a doctor, nurse, psychologist, social worker, chiropractor podiatrist, therapist, optometrist, osteopath, clergy, Christian Science practitioner, or a person affiliated with a self-help program such as Alcoholics Anonymous, a substance abuse program or a weight loss program.)

1. Have YOU or any of your listed DEPENDENTS been diagnosed or treated in the past five years by a medical or social practitioner for any of the following reasons?

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. Acquired Immune Disease (AIDS)			21. Scoliosis			41. High Blood Pressure / Hypertension		
2. AIDS Related Complex (ARC)			22. Spina Bifida			42. If yes, give last 3 pressures & dates		
3. Tested Positive for Virus HIV			23. Bodily Deformities or Disabilities			A. B. C.		
4. Alcohol or Drug Dependency			24. Cancer / Leukemia / Lymphoma / Melanom			43. Pacemaker		
5. Attempted Suicide			25. Cataracts			44. Diabetes or Sugar in Urine		
6. Depression			26. Crohn's Disease / Ulcerative Colitis			45. If yes,give last 3 blood sugars & dates		
7. Nervous Breakdown			27. Diverticulitis			A. B. C.		
8. Other Nervous / Emotional Problems			28. Gastric / Peptic / Stomach Ulcer			46. Gall Stones		
9. Alzheimer's Disease / Memory Loss / Mini Stroke			29. Intestinal Polyps			47. Kidney Stones		
10. Other Neurological Disorders			30. Other Bowel / Stomach Problems or Disord			48. Kidney/ Urinary Problems or Disorders		
11. Anemia			31. Cerebral Palsy			49. Prostate Disease or Problems		
12. Anorexia / Bulemia			32. Congenital Disease / Defect			50. Cirrhosis of Liver		
13. Arthritis (Osteo, Rheumatoid, etc.)			33. Cystic Fibrosis			51. Other Liver Problems or Disorders		
14. Gout			34. Epilepsy / Seizures / Convulsions / Fits			52. Mulitple Sclerosis		
15. Asthma			35. Hemophilia/Bleeding Problems or Disorder			53. Paralysis		
16. Chronic Bronchitis			36. Congestive Heart Failure			54. Parkinson's Disease		
17. Emphysema			37. Coronary Artery Disease			55. Organ Recipient / Transplant		
18. Other Lung Disorders			38. Heart Attack / M.I.			56. Stroke (Date)		
19. Back / Spinal Problems or Disorders			39. Heart Disease Problems or Disorders			57. Tumors / Growths		
20. Back Strain / Sprain			40. Heart Surgery			58. Venereal Disease		

2. If any of the conditions are checked "YES" please explain below,(use additional paper if necessary). Please indicate specific location of condition (example:left hand), details of injury or condition.

PATIENT'S NAME	CONDITION NUMBER	DIAGNOSIS AND TYPE OF TREATMENT	HOSPITALIZED	ATTENDING PHYSICIAN	DATE(S) OF TREATMENT(S)
			☐ YES ☐ NO		FROM: TO:
			☐ YES ☐ NO		FROM: TO:
			☐ YES ☐ NO		FROM: TO:

3. Have YOU or any of your listed DEPENDENTS consulted a medical or social practitioner or been hospitalized during the past five years for any conditions not listed in question #1?

PERSON	MEDICAL CONDITION	TREATMENT / MEDICATION	DATE TREATED OR CONSULTED WITH DOCTOR	DEGREE OF RECOVERY
			FROM TO	
			FROM TO	
			FROM TO	

4. Has future surgery, diagnostic testing or medical treatment been recommended for YOU or any of your listed DEPENDENTS on this questionnaire? ☐YES ☐ NO
If yes, please explain. Give name, date, ailment and the type of operation, test or treatment recommended.

5. Have YOU or any of your listed DEPENDENTS had re-ocurring symptoms such as headaches,nausea,diarrhea,or persistent pain for which you have not sought treatment? ☐YES ☐NO
If yes, please explain.

6. Have YOU or any of your listed DEPENDENTS taken prescribed medication within the last 12 months? ☐YES ☐ NO If yes, please explain below.

NAME OF PERSON	MEDICATION / AMOUNTS PER DAY	FOR WHAT CONDITION

7. Are YOU or any of your listed DEPENDENTS herein now pregnant? ☐ YES ☐ NO If yes, due date?
Is this pregnancy high risk or expected to have complications. (i.e., cesarean section)? ☐ YES ☐NO If yes, please explain and provide physicians name and address.

8. Have YOU or any of your listed DEPENDENTS smoked within the last 5 years? ☐YES ☐NO If yes, please explain below.

NAME OF PERSON	NUMBER OF CIGARETTES PER DAY	NUMBER OF YEARS SMOKING

9. Do YOU or any of your listed DEPENDENTS have a family member (parents, grandparents, brothers, sisters) who has or has expired due to heart disease, stroke, cancer, diabetes, or mental illness? ☐ YES ☐ NO If yes, please explain.

10. Have any insurance company refused or restricted any health coverage for YOU or any of your listed DEPENDENTS within the last five years? ☐YES ☐NO If yes, please explain.

11. List ANYONE on this application under age 65 who is covered by MEDICARE:

12. Do YOU or any of your listed DEPENDENTS have a condition covered by Workers Compensation? ☐YES☐ NO If yes, please list condition and the Workers Compensation number.

TO BE SIGNED BY APPLICANT (AND SPOUSE IF SPOUSE IS APPLYING FOR COVERAGE)

I have read this entire questionnaire and I declare all information, statements and answers herein to be true and complete. I also understand and agree with CBA, Inc. that coverage, if issued, will be issued in full reliance on this questionnaire and that any untrue or incomplete information, statements or answers, whether intentional or not, in this questionnaire can result in denial of a claim, or recision of coverage. I hereby authorize CBA, Inc. to present a photocopy of this questionnaire to any medical or social practitioner or medical institution and I request the release to CBA, Inc. of all records of information of medical examination,history and treatment or any applicant. I hereby consent, on my own behalf and on behalf of all dependents to be covered,to the release and disclosure of such medical information to CBA, Inc. for the purpose of evaluating my enrollment application. I will also be responsible for any cost incurred by CBA, Inc. to receive medical information needed to make a decision for coverage.

Date Applicant's Signature

Date Spouse's Signature (if applying for coverage)