



Employee Health Questionnaire

Group name				Benefits: <input type="checkbox"/> Employee only <input type="checkbox"/> Employee/Spouse <input type="checkbox"/> Employee/Child(ren) <input type="checkbox"/> Family			
Name	Date of birth (MM/DD/YYYY)	Height	Weight	Name	Date of birth (MM/DD/YYYY)	Height	Weight
Employee				Spouse			
Dependent 1				Dependent 2			
Dependent 3				Dependent 4			
Dependent 5				Dependent 6			

Please answer the following questions for yourself AND any eligible dependents

Please note that no one will be denied benefits on an individual basis due to answers provided below.

- Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary with the exception of AIDS/HIV? Yes No
 If "Yes", please explain below.
- Has anyone been treated for a COVID illness? Yes No
 If "Yes", please explain below.
- Is anyone currently being treated or been advised to seek treatment or counseling for any of the following? Yes No
 If "Yes", please check condition(s) that apply.

<input type="checkbox"/> Cancer	<input type="checkbox"/> Kidney disorder	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Chronic respiratory disease
<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Transplants	<input type="checkbox"/> Chemical dependency/alcoholism	<input type="checkbox"/> Muscular disorder
<input type="checkbox"/> Blood disorders	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Brain tumor	<input type="checkbox"/> Mental illness
<input type="checkbox"/> Obesity	<input type="checkbox"/> Crohn's Disease/ulcerative colitis	<input type="checkbox"/> Back/spinal disorder	<input type="checkbox"/> Nervous system disorders
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Stroke	
<input type="checkbox"/> Currently pregnant? If yes, due date: <input style="width: 100px;" type="text"/>		<input type="checkbox"/> Other: _____	
- Do you or your dependents regularly take medication? Yes No
 If "Yes", please explain below.
- In the past five years have you or any of your dependents been diagnosed with AIDS or HIV? Yes No
 If "Yes", please explain below.

Explain "Yes" answer to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Question no.	Individual name	Diagnosis	Treatment	Medication	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Employee name	Social Security no.
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I represent that all answers on this Questionnaire are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to benefits or premium equivalent rates. Material misrepresentations in this application may result in increased premium equivalent rates, or benefits being denied, rescinded or cancelled.

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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

NOTICE OF INFORMATION PRACTICES: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164). I also understand that under the HIPAA Privacy Regulations, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I understand that the length of time such authorization shall remain valid shall be no longer than 30 months from the date the authorization is signed.

I agree that this executed Questionnaire will become part of the application and any contract issued on it.

Signature X	Date (MMDDYYYY)
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