



Corporate Plan Management
1220 SW Executive Drive
Topeka, KS 66615
785-273-8398

Health Questionnaire

Section 1 Employer Information

Employer Name: _____ Date of hire: _____
Employer Address: _____
City: _____ State: _____ Zip: _____
Daytime Phone # _____

Section 2 Employee Information

Employee Name: _____ DOB: _____
Last First M.I.
Address: _____
City: _____ State: _____ Zip: _____
Job Title: _____ Marital Status: Single Married Divorced Widowed

Section 3 Other Insurance Coverage

Are you or any dependents disabled Yes No If yes, please indicate names _____
Do you or your spouse have other health insurance? Yes No
If yes, Carrier name _____ Name of Policy Holder _____
List all covered dependents _____

Section 4 Subscriber / Dependents (IMPORTANT: Include employee and all dependents)

First Name	MI	Last Name	SS#	DOB	Age	M/F	Tobacco Use Yes/No

Section 5 Health Plan Enrollment I decline participation
 I elect to participate
 Employee Only Employee / Spouse
 Employee / Child(ren) Family

Section 6 Health Information

Employee: Height ___ feet ___ inches; Weight ____ Spouse: Height ___ feet ___ inches; Weight ____

1. Has any covered family member been diagnosed or treated for any of the following conditions in the past five (5) years? **(Include only those who will or could possibly be covered under this health plan)**

A. Cardiac Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	H. Aids / Immune System Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
B. Cancer (any form)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	I. Alcohol / Drug Abuse	Yes <input type="checkbox"/>	No <input type="checkbox"/>
C. Diabetes	Yes <input type="checkbox"/>	No <input type="checkbox"/>	J. Mental / Nervous Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
D. Kidney Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	K. Neuromuscular Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
E. Respiratory Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	L. Stomach / Gastrointestinal	Yes <input type="checkbox"/>	No <input type="checkbox"/>
F. Liver Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>	M. SIZES, convulsion, epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>
G. High Blood Pressure	Yes <input type="checkbox"/>	No <input type="checkbox"/>	N. Arthritis, Back, Bone, Joint Disorder	Yes <input type="checkbox"/>	No <input type="checkbox"/>
2. Has any covered family member had an application for insurance declined, postponed, rated, or otherwise modified? Yes No
3. Has any covered family member had any medical conditions in the past 24 months requiring medical care, prescription management, or hospitalization in the amount of \$5,000 or more? Yes No
4. Are any covered family members anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? If Yes please provide information below. Yes No
5. Are any covered family members currently pregnant or suspect they may be pregnant? If Yes, please provide due date and detail in space provided below. Yes No

Question Number	Family Member	Disease / Diagnosis/ Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications – Please list any medications, prescriptions, or injections taken in the past 12 months.

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

AUTHORIZATION: My signature below hereby authorizes any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge pertaining to the health of me or my dependents listed on this form (Page 1, Sections 2 and/or 4) to provide such information to Corporate Plan Management (Health Plan Administrator). A photographic copy of this authorization shall be considered permissible. This authorization will remain in effect for six (6) months from the date below.

Employee Signature: _____ Date: _____