

Southwest Kansas Chamber Alliance

Health and Wellness Plan

Corporate Plan Management
1220 SW Executive Drive
Topeka, KS 66615
www.corporateplan.net



Health Questionnaire

Section 1 Employer Information

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

Section 2 Employee Information

Employee Name (Last, MI, First): _____ DOB: _____
Address: _____ Daytime Phone # _____
City: _____ State: _____ Zip: _____

Section 3 Other Insurance Coverage (coverage in addition to the Section 1 Employer group 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	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

Preferred Health Plan Option:

___ \$1,000 Ded. ___ \$2,500 Ded. ___ \$5,500 Ded. ___ \$4,000 HSA ___ \$7,900 DPC Option

Preferred Rx Option:

___ Standard Co-pay ___ All Rx 50% except \$0 Generics ___ Standard co-pay excluding Specialty

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. Seizures, 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? Yes No

If Yes to 1, 2, 3, 4, OR 5, please give detail in space provided below.

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: _____

In accordance with the HIPAA Privacy Laws and Protected Health Information (PHI), CPM may disclose Summary Health Information for the purposes of obtaining premium bids for the proposed Plan only. All electronically submitted and disseminated PHI is conducted with HIPAA compliant encryption technology.