NVMA

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: ________________
Job Title: ________________________________ Email: ____________________________________
Status: _____ Single _____ Married _____ Divorced _____ Widowed _____ Retired

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 Plan Option:

_____ $1,500 Deductible _____ $3,000 Deductible _____ $5,000 Deductible ______ $6,000 HSA Ded.

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 ☐ No ☐	H. Aids / Immune System Disorder	☐ Yes ☐ No
B. Cancer (any form)	Yes ☐ No ☐	I. Alcohol / Drug Abuse	☐ Yes ☐ No
C. Diabetes	Yes ☐ No ☐	J. Mental / Nervous Disorder	☐ Yes ☐ No
D. Kidney Disorder	Yes ☐ No ☐	K. Neuromuscular Disorder	☐ Yes ☐ No
E. Respiratory Disorder	Yes ☐ No ☐	L. Stomach / Gastrointestinal	☐ Yes ☐ No
F. Liver Disorder	Yes ☐ No ☐	M. Seizures, convulsion, epilepsy	☐ Yes ☐ No
G. High Blood Pressure	Yes ☐ No ☐	N. Arthritis, Back, Bone, Joint Disorder	☐ Yes ☐ No

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: _____________________