

**Policyholder Name:** \_\_\_\_\_ **Member #** \_\_\_\_\_

**This questionnaire is for use by policyholders requesting to enroll a legal dependent(s). Please include information on all family members you wish to add.**

Please list all dependent(s) you wish to add to your policy:					
Name	Sex/Gender (M/F)	Date of Birth	Height	Weight	Date of last physician visit
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

**Medical Questions**

Please answer all questions with a “Yes or No”. Incomplete applications will be returned to you for completion, which may delay the effective date of your coverage.

Within the past **five (5) years**, have you or any applying dependents ever had signs or symptoms, or been told to have, or been treated or diagnosed with a condition for which consultation was or will be sought for any of the conditions below? **Check Yes or No to ALL questions.**

**Please explain and provide the full details for each “Yes” answer to any condition(s) checked in the following boxes. (Attach additional sheets if necessary). Include for whom (self, spouse, child name) diagnosis, date of diagnosis, date of last treatment, and indicate if condition is mild or moderate or severe and indicate if condition is ongoing, and list any medications with dosages.**

*Example:*

Q#	Name (self or dependent)	Date Treatment Began Ended *	Treatment Rendered (Tx) Current Status (Recovered or still in Treatment)	Name of Prescription (Rx) Are you still taking?	Additional details
3	Jane Doe	Began: May 1999	Tx: Inhaler Prescribed	Rx: Entex 1 tablet p/day	Mild Bronchitis
		Ended: ongoing	Recovered? Yes x No <input type="checkbox"/>	Still taking? X Yes <input type="checkbox"/> No	

Note: If treatment has ended, please indicate date; if treatment has not ended, please indicate “ongoing.”

1. AIDS or HIV+ List all applicants to whom the condition applies:	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Alcoholism (in lifetime): List all applicants to whom the condition applies:  Does any applicant currently consume 4 or more alcoholic beverages a day? <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies:	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>3. Allergies  Has an applicant taken a prescribed medication in the past year and/or are receiving immunotherapy injections? <input type="checkbox"/> Yes <input type="checkbox"/> No  List all applicants to whom the condition applies:</p> <p>If receiving immunotherapy injections, indicate how often:  <input type="checkbox"/> 1 – 2 times per year <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly/weekly  If you do not receive immunotherapy injections, do you take seasonal prescribed medication?  <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for a duration of: <input type="checkbox"/> less than 5 year <input type="checkbox"/> more than 5 years</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. Arthritis  If “Yes,” have you required medication for pain relief? <input type="checkbox"/> Yes <input type="checkbox"/> No  List all applicants to whom the condition applies:</p> <p>Do you have osteoarthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No  List all applicants to whom the condition applies:</p> <p>If “yes” to osteoarthritis, medication is required for pain relief of symptoms which are considered  <input type="checkbox"/> Mild or <input type="checkbox"/> Moderate to Severe  Prescribed Medication: <input type="checkbox"/> Diclofenac Sodium <input type="checkbox"/> Methotrexate or Arthrotec  <input type="checkbox"/> Arthrotec, Celebrex or Bextra <input type="checkbox"/> Acthar  <input type="checkbox"/> Other - please provide name(s) of applicant(s) and details of other medications:  _____</p> <p>Do you have rheumatoid arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No  List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Asthma  List all applicants to whom the condition applies:</p> <p>Do(es) the applicant(s) with asthma smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are symptoms:  <input type="checkbox"/> Mild or Seasonal? Since initial treatment/diagnosis: <input type="checkbox"/> less than 2 yrs <input type="checkbox"/> 2 – 4 yrs <input type="checkbox"/> 4+ yrs  <input type="checkbox"/> Moderate? Since initial treatment/diagnosis: <input type="checkbox"/> less than 2 yrs <input type="checkbox"/> 2 – 4 yrs <input type="checkbox"/> 4+ yrs  <input type="checkbox"/> Severe?</p> <p>What medications are prescribed for asthma? <input type="checkbox"/> Alupent, Brethine, Isoetharine HCL, or Maxair  <input type="checkbox"/> Flovent, Intal Inhaler, Theophylline, or Tilade <input type="checkbox"/> Aerobid or Serevent  <input type="checkbox"/> Accolate or Uniphyl <input type="checkbox"/> Singulair, Zyflo, Filmtab, or Advair Diskus <input type="checkbox"/> Acthar or Xolair  <input type="checkbox"/> Other (please provide name(s) of applicant(s) and details of other medications): _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. Backache, sprain or strain  All fields need to be completed for each individual with the “Yes” response.  Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. Blood disorder including coagulation defect, hemophilia, polycythemia vera, sickle cell anemia or thrombocytopenia purpura (bleeding disorder)  List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>8. Cancer or other malignancy including leukemia, lymphoma, myeloma (in lifetime) List all applicants to whom the condition applies:</p> <p>Was basal or squamous skin cancer the only form of cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Other form of cancer  Select all that applies to <b>basal or squamous cell skin cancer</b>.  <input type="checkbox"/> Untreated  <input type="checkbox"/> Treated  <input type="checkbox"/> Treated with one or more additional previous excision</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9. Abnormal pap or cervical dysplasia [<b>only requires a response from female applicants</b>] All fields need to be completed for each individual with a “Yes” response. Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No  If cervical dysplasia, indicate type: <input type="checkbox"/> Atypical squamous cell  <input type="checkbox"/> Squamous cell, Low Grade  <input type="checkbox"/> Squamous cell, High Grade  <input type="checkbox"/> Glandular cell  How much time has elapsed since your pap tests have been normal? _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>10. Connective tissue disease including systemic lupus, polymyositis, psoriatic arthritis, Reiter’s, rheumatoid arthritis, scleroderma or Sjogren’s? List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>11. Cyst, benign All fields need to be completed for each individual with a “Yes” response: Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No  Details: <input type="checkbox"/> Baker’s <input type="checkbox"/> Sebaceous <input type="checkbox"/> Bartholin’s <input type="checkbox"/> Dentigerous <input type="checkbox"/> Nabothian  Location on body? _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>12. Disk or disease of the spine <b>Herniated or ruptured?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies:   Select all which apply to applicant(s) who have undergone surgery:  <input type="checkbox"/> Issue resolved, no current treatment or pain relief medication required.  Number of years since treatment:  <input type="checkbox"/> Less than 2 years  <input type="checkbox"/> Between 2 to 5 years  <input type="checkbox"/> For more than 5 years  <input type="checkbox"/> Continues to require treatment and/or pain relief medication   <b>Degenerative?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>Select all which apply to applicant(s) who have a degenerative condition:</p> <p><input type="checkbox"/> No treatment or pain relief medication required</p> <p><input type="checkbox"/> Physical therapy, chiropractic care or other forms of treatment required in the past 6 months equal up to 3 visits</p> <p><input type="checkbox"/> Physical therapy, chiropractic care or other forms of treatment required in the past 6 months equal more than 3 visits</p>	
<p>13. Diabetes (excluding gestational diabetes over a year ago) List all applicants to whom the condition applies:</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>14. Ear, nose, or throat including deviated septum, otitis media, Meniere's, sinusitis, tonsillitis or vertigo</p> <p>All fields need to be completed for each individual with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes    <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>15. Endocrine or thyroid disorder including Addison's disease, graves, goiter, or Hashimoto's. List all applicants who respond "Yes" to Addison's disease or hyperparathyroidism:</p> <p>If "Yes" for other conditions, provide details for each individual with a "Yes" response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes    <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>16. Eye disorders</p> <p><b>Macular degeneration?</b> List all applicants to whom the condition applies:</p> <p><b>Cataract, detached retina, keratoconus or strabismus?</b> List all applicants to whom the condition applies:</p> <p>Select all for applicants who have undergone a surgical procedure for this condition: Check which applies to <b>cataract</b>: Operated (with or without intraocular lens): <input type="checkbox"/> Less than 6 months ago    <input type="checkbox"/> 6 months to 2 years <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to <b>keratoconus</b>: Operated: <input type="checkbox"/> Less than 2 years ago    <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to <b>stabismus</b>: Operated: <input type="checkbox"/> Less than 2 years ago    <input type="checkbox"/> More than 2 years ago</p> <p>Check which applies to <b>detached retina</b> (due to injury): Operated, normal vision: <input type="checkbox"/> Less than 2 years ago    <input type="checkbox"/> More than 2 years ago</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>

<p><b>Glaucoma?</b> List all applicants to whom the condition applies:</p>	
<p>17. Fibroid, uterine <b>[only requires a response from female applicants]</b> List all applicants to whom the condition applies:</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>18. Fracture or joint replacement (in lifetime) List all applicants to whom a “Yes” response would apply:</p> <p>Did this involve a knee, hip or head of femur? <input type="checkbox"/> Yes <input type="checkbox"/> No If a fracture, did this require pins or hardware? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If the above does not apply or your response was “No,” please provide information for each individual with a “No” response. Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes    <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If spine was fractured, please indicate if compression fracture: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>19. Gastrointestinal disorder including Crohn’s, esophageal reflux, esophagitis, diverticulitis, gastritis, hemorrhoids, hiatal hernia, irritable bowel syndrome, pancreatitis, peptic ulcer disease, ulcerative colitis (in lifetime) List all applicants to whom a “Yes” response would apply for ulcerative colitis, Crohn’s, or pancreatitis:</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes    <input type="checkbox"/> No                      Recovered: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
<p>20. Genitourinary (urinary organs, including kidneys and the reproductive organs) Female disease including chronic cystitis, excessive uterine bleeding, endometriosis, or incontinence Male disease including enlarged prostate or prostatitis List all applicants to whom the condition applies:</p>	<p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>

<p>All fields need to be completed for each individual with a “Yes” response:  Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>21. Heart disease including angina, coronary artery disease, cardiomyopathy, congestive heart failure, heart attack or a history of an angioplasty, cardiac bypass or pacemaker (ICD) (in lifetime, not just over the last 5 years)  List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>22. Hepatitis, liver disease/cirrhosis  If “Yes” to liver disease/cirrhosis, list all applicants with a “Yes” response:  If yes to hepatitis, provide details for every applicant with a “Yes” response:  Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No  Type: <input type="checkbox"/> Type A   <input type="checkbox"/> Type B   <input type="checkbox"/> Type C  Indicate if ALT test has been within normal limits in the past year. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>23. Hypertension or high cholesterol</p> <p><b>Hypertension?</b>  List all applicants to whom the condition applies:</p> <p>Select all which apply to applicant(s) who have this condition:  <input type="checkbox"/> Mild  <input type="checkbox"/> Moderate  <input type="checkbox"/> History of hospitalization for this condition (Less than 3 years ago)  Does the applicant(s) currently smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Prescribed Medication:  <input type="checkbox"/> Cardizem, Cozaar, or Plendil    <input type="checkbox"/> Hytrin, Lotrel or Adalat    <input type="checkbox"/> Catapres, Coreg  Please provide name(s) of applicant(s) and details of other medications:</p> <p><b>High cholesterol?</b>  Select all which apply to applicant(s) who have this condition:  <input type="checkbox"/> Was the applicant(s) last total cholesterol reading less than 200 milligrams/dL?  <input type="checkbox"/> Was the applicant(s) last total cholesterol reading between 201 and 219 milligrams/dL?  <input type="checkbox"/> Was the applicant(s) last total cholesterol reading between 220 and 239 milligrams/dL?  <input type="checkbox"/> Was the applicant(s) last total cholesterol reading more than 240 milligrams/dL?</p> <p>Prescribed Medications:  <input type="checkbox"/> Gemfibrozil, Welchol   <input type="checkbox"/> Zetia, Advicor   <input type="checkbox"/> Lofibra, Lopid, Nlaspan   <input type="checkbox"/> Trico, Crestor  <input type="checkbox"/> Lovastin, Lipitor, Lescol, Mevacor, Pravachol, Zocor  Please provide name(s) of applicant(s) and details of other medications:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>24. Infertility [<b>only requires a response from female applicants between the ages of 20-45</b>] List all applicants to whom the condition applies:</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>25. Kidney disease including chronic renal failure, glomerulonephritis, Nephrotic syndrome, or polycystic kidney (Refer to question 26 for kidney stone) List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>26. Kidney stone List all applicants who had a kidney stone in the past year:</p> <p>Give details for each individual with a “Yes” response:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> One stone passed spontaneously more than 1 year ago</li> <li><input type="checkbox"/> Two or more stones passed spontaneously more than 1 year ago</li> <li><input type="checkbox"/> Lithotripsy required for removal of stone/stones</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>27. Mental health or eating disorder including anorexia nervosa, bipolar disorder, bulimia, major depression, obsessive-compulsive, post-traumatic stress or schizophrenia (in lifetime, not just over the last years) If “Yes” for bipolar disorder, bulimia, major depression or schizophrenia, list all applicants with a “Yes” response:</p> <p>If “Yes” for other mental health conditions listed, give details for each individual: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Has the applicant ever been hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>28. Migraines or chronic fatigue syndrome</p> <p><b>Chronic Fatigue Syndrome?</b> List all applicants to whom the condition applies:</p> <p><b>Migraine?</b> List all applicants to whom the condition applies:</p> <p>Please indicate for each applicant to whom the condition applies:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Occasional mild attacks</li> <li><input type="checkbox"/> 3 to 6 moderate attacks per year, multiple medication</li> <li><input type="checkbox"/> 6 or more moderate attacks per year, multiple medication</li> </ul> <p>Prescribed Medication:</p> <p><input type="checkbox"/> Maxalt, Zomig    <input type="checkbox"/> Inderal, Imitrex, Amerge, Axert, Frova    <input type="checkbox"/> Depakote    <input type="checkbox"/> Topamax</p> <p>Please provide name(s) of applicant(s) and details of medications:</p> <p>List all applicants who had one or more emergency room visits in the past two years:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>29. Musculoskeletal disorder including ALS(Amyotrophic Lateral Sclerosis), bursitis, bone spur, bunion, carpal tunnel, cruciate, fibromyalgia, gout, hammer toe, ligament injury, meniscus tear, muscular dystrophy, rotator cuff, spondylosis, spinal stenosis or tendonitis</p> <p>If “Yes” for ALS, fibromyalgia, muscular dystrophy, reflex sympathetic dystrophy, spondylosis or spinal stenosis, list all applicants with a “Yes” response:</p> <p>All fields need to be completed for each individual with a “Yes” response:  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If “Yes” to gout, please indicate the average number of attacks per year:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>30. Neurological disorder including brain injury, Alzheimer’s, Bell’s palsy, cerebral palsy, epilepsy, Guillain-Barre’, multiple sclerosis, myasthenia gravis, Parkinson’s, or spinal cord injury</p> <p>List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>31. Osteoporosis or osteopenia</p> <p>List all applicants <b>under the age of 50 years</b> to whom the condition applies:</p> <p>List all applicants <b>above the age of 50 years old</b> that have osteoporosis or osteopenia:</p> <p>Please indicate for each applicant to whom the condition applies:</p> <p><input type="checkbox"/> Mild condition  <input type="checkbox"/> Moderate condition  <input type="checkbox"/> Severe condition</p> <p>Prescribed Medication: <input type="checkbox"/> Actonel, Fosamax    <input type="checkbox"/> Boniva, Evista    <input type="checkbox"/> Forteo</p> <p>Please provide name(s) of applicant(s) and details of other medications):</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>32. Pediatric disorders including congenital birth defects, cleft palate, Down syndrome, or cardiac defect</p> <p>List all applicants to whom the condition applies:</p> <p>All fields need to be completed for each individual with a “Yes” response:  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If “Yes” to cardiac defect, please indicate the specific diagnosis or condition:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>33. Polyp</p> <p><b>Vocal cord polyp?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No List all applicants to whom the condition applies:</p> <p><b>Nasal or gastrointestinal polyp?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Nasal polyp</b> List all applicants to whom the condition applies:</p> <p>Select all that applies to nasal polyp:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Operated and no recurrence of one or more polyps <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 3 years ago</li> <li><input type="checkbox"/> More than 3 years ago</li> </ul> </li> <li><input type="checkbox"/> Operated and recurrence of one or more polyps</li> <li><input type="checkbox"/> Not operated on</li> </ul> <p><b>Gastrointestinal or rectal polyp</b> List all applicants to whom the condition applies:</p> <p>Select all that applies to gastrointestinal or rectal polyp:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Operated and one operation with less than 4 polyps: <ul style="list-style-type: none"> <li><input type="checkbox"/> Less than 2 years ago</li> <li><input type="checkbox"/> More than 2 years ago</li> </ul> </li> <li><input type="checkbox"/> Operated on and numerous or more than 4 polyps</li> <li><input type="checkbox"/> Not operated on</li> </ul>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>34. Are any applicants currently pregnant or an expectant father? List all applicant to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>35. Pulmonary or respiratory disorder including bronchitis, chronic obstructive airway, cystic fibrosis, emphysema, pneumonia, pulmonary embolism or tuberculosis</p> <p>If “Yes” to chronic obstructive airway, cystic fibrosis, emphysema or pulmonary embolism, list all applicants with a “Yes” response:</p> <p>All fields need to be completed for each individual with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate if hospitalization was required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>36. Have any applicants used illegal drugs and/or recreational drugs in the past 5 years?</p> <p>If “Yes” for conditions listed above, give details for each applicant with a “Yes” response: Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No Please indicate if hospitalization was required: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>37. Sexually transmitted disease including genital herpes or genital warts (HPV)</p> <p>If "Yes" for conditions listed above, give details for each applicant with a "Yes" response:  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>38. Transplant (in lifetime, not just over the last 5 years)?  List all applicants to whom the condition applies:</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>39. Vascular disease including aneurysm, stroke, blood clot, varicose veins, peripheral vascular disease, or Raynaud's</p> <p>If Yes to stroke or peripheral vascular disease, list all applicants with a "Yes" response:</p> <p>If "Yes" for conditions listed above, give details for each applicant with a "Yes" response:  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>40. Have any applicants been treated for, diagnosed, or advised on any other medical condition(s) that has not been addressed above?</p> <p>If "Yes" for conditions listed above, give details for each applicant with a "Yes" response:  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p> <p>Still taking: <input type="checkbox"/> Yes <input type="checkbox"/> No      Recovered: <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>41. Have any applicants been told by a medical professional that medication or treatment may be needed in the future? If yes, provide details below.  Name(s): _____</p> <p>Treatment Date Began: _____ Ended: _____</p> <p>Condition, Treatment Current status: _____</p> <p>Medication, Frequency, Dosage: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

<p>42. Any hospitalizations or surgeries past or present not previously indicated? If yes, provide details below.  Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition, Treatment Current status: _____  Medication, Frequency, Dosage: _____</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>43. Are any applicants currently taking prescription medications (except for contraceptives to prevent pregnancy) not previously listed? If yes, provide details:  Name(s): _____  Treatment Date Began: _____ Ended: _____  Condition or Diagnosis: _____  Medication, Frequency, Dosage: _____  Still taking: <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Consent**

**I agree:** By signing this Application I warrant that I have read this Application and warrant my current and continuing authority to act on behalf of myself and all Dependents for whom I have legal authority to act on behalf of, with respect to every provision of the Subscriber Agreement. All information on this form is correct and true. I understand that is the basis on which coverage is issued under the plan. I understand I will receive my Presbyterian Insurance Company Subscriber Agreement, which contains the benefits, limitations and exclusions applicable to my healthcare plan.

**I hereby consent,** to the extent permitted by applicable law, to the use by or the release of my protected health information (PHI) by any person or entity including without limitation, practitioners, providers, and insurance companies to Presbyterian Insurance Company or its designees for any permitted purpose, including but not limited to, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the treatment, payment or healthcare operations activities of Presbyterian Insurance Company. This consent shall not permit a use or disclosure of PHI when an authorization is required by law.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents information in an Application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties. Presbyterian Insurance Company Inc. may terminate a member for any type of fraudulent activity.**

_____ Name of applicant ( <i>Please Print</i> ) (or legal guardian if applicant is a minor)	X _____ Signature of applicant ( <i>Required</i> ) (or legal guardian if applicant is a minor)	_____ Today's Date
_____ Name of applicant's spouse	X _____ Signature of applicant's spouse	_____ Today's Date