

**D. HEALTH QUESTIONNAIRE**



**Important:**

- Check with your employer to see if you are required to complete this health questionnaire.
- You must answer every question for each family member to be enrolled.  
Information provided in this section will not result in a denial of coverage.
- You must sign, seal, and return this completed application to your employer.

	Subscriber	Spouse/ Domestic Partner	Dependent #1	Dependent #2	Dependent #3	Dependent #4
1. How many times have you been hospitalized in the past 12 months, except for pregnancy?	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More	<input type="radio"/> None <input type="radio"/> 1 <input type="radio"/> 2 or More
2. Do you currently use, or have you in the last ten years used, tobacco on a regular basis?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. Do you have any pending surgery, treatment, examination, evaluation or test for any condition that has been advised in the last three years, except for pregnancy?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Have you ever been treated for, or has a doctor advised you that you have any of the following conditions? <b>Important:</b> <b>Check all that apply or "None of the above", and continue question on next page.</b>	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - Basal <input type="radio"/> Melanoma <input type="radio"/> Other Cancer:  <input type="radio"/> Chronic Fatigue Syndrome <input type="radio"/> Crohn's or Ulcerative Colitis <input type="radio"/> Depression or Anxiety <input type="radio"/> Diabetes <input type="radio"/> Drug Addiction <input type="radio"/> Eating Disorder, Anorexia Nervosa/ Bulimia <input type="radio"/> Emphysema/COPD <input type="radio"/> Gallstones <input type="radio"/> Heart Condition <input type="radio"/> Heart Valve Condition <input type="radio"/> Hepatitis C <input type="radio"/> Hernia <input type="radio"/> High Blood Pressure <input type="radio"/> High Cholesterol <input type="radio"/> Kidney/Bladder Condition <input type="radio"/> Liver Condition	<input type="radio"/> AIDS, ARC <input type="radio"/> Alcoholism <input type="radio"/> Aneurysm <input type="radio"/> Asthma <input type="radio"/> Back/Neck Pain or Injury <input type="radio"/> Bone Marrow Transplant Cancer: <input type="radio"/> Breast Cancer <input type="radio"/> Colon Cancer <input type="radio"/> Leukemia <input type="radio"/> Lung Cancer <input type="radio"/> Prostate Cancer <input type="radio"/> Skin Cancer - 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(continue on next page)

(cont'd from page A-2)

	Subscriber	Spouse/ Domestic Partner	Dependent #1	Dependent #2	Dependent #3	Dependent #4
4.	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    	<input type="checkbox"/> Lupus/SLE <input type="checkbox"/> Menopause <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> MS/ALS/Parkinson's/Alzheimer's <input type="checkbox"/> Pacemaker <input type="checkbox"/> Prostate Condition <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Seizures <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Stomach or Intestinal Problem <input type="checkbox"/> Stroke <input type="checkbox"/> Ulcer <input type="checkbox"/> None of the above <input type="checkbox"/> Other    
5. Do you have unexplained and/or undiagnosed symptoms, not associated with conditions in question 4? <b>Important: Check all that apply or "None of the above"</b>	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Glands <input type="checkbox"/> Chest Pain <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Abdominal or Pelvic Pain <input type="checkbox"/> Loss of Consciousness <input type="checkbox"/> Unexplained Weight Loss <input type="checkbox"/> Rectal Bleeding <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Dizziness <input type="checkbox"/> Rash <input type="checkbox"/> Skin Lesions <input type="checkbox"/> Lumps <input type="checkbox"/> None of the above
6. Are you regularly taking any prescription medications? If Yes, please list each medication:	<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      
7. For women, are you pregnant now?	<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

California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

**Additional copies of this Health Questionnaire are available from your employer for completion by family members age 18 and older, upon request. Any missing information will affect your group's monthly rate. The information provided is confidential and will only be used for rating purposes and not for any other purpose.**

**Once you've answered all the questions, sign the authorization below. For your privacy, moisten edges, seal, and submit to your employer.**

**Please read, sign and date below**  
I certify that, to the best of my knowledge, the above information is true and complete.

**X** Employee/Subscriber Signature Date