



101 S.E. Third Street, Evansville, IN 47708

Medical Questionnaire

Small Group (26-50 Eligible Employees)

Employer: _____

Employee Name: _____	SS#: _____	<input type="checkbox"/> Employee Only
Date of Birth: _____	State of Residence: _____	<input type="checkbox"/> Employee + Spouse
	Zip Code: _____	<input type="checkbox"/> Employee + Child(ren)
		<input type="checkbox"/> Family

Please answer the following questions to the best of your knowledge for the person(s) to be insured. Give details to questions answered "yes" in the space provided. **If more room is needed, use the back of this form.**

- 1.) Have you or any eligible dependents been treated for a serious illness that required hospitalization or had a medical claim totaling \$5,000 or more in the last 12 months? YES NO
- 2.) Have you or any eligible dependents been advised to have surgery or diagnostic testing in the last 6 months or anticipate hospitalization for any reason? YES NO
- 3.) Have you or any eligible dependents received a transplant or been told they are a possible transplant candidate? YES NO
- 4.) Have you or any eligible dependents been treated for a serious illness or injury in the past 5 years (i.e. cancer, diabetes, cardiovascular disease, substance abuse, mental illness, head injury, pre-mature birth, Alzheimer's Disease, Hodgkin's Disease, Leukemia, Liver, Kidney, Bladder or Prostate Disorder, Asthma, etc.)? YES NO

If you have answered "YES" to any of the questions above, please provide the following information for each individual.

Question #	Gender	Age	Health Condition	Diagnosis Date	Current Status / Prognosis

CERTIFICATION

I REPRESENT that the answers given above are complete and true to the best of my knowledge. I understand that any fraudulent or intentional misrepresentation of material fact, as to the presence or absence of pre-existing medical conditions, impairments or diseases will void my membership and rights to benefits. I must report to Welborn Health Plans any change in my health status after I have submitted this questionnaire and prior to acceptance. Welborn Health Plans has the right to request information regarding any change in health status or impairment or disease which occurs between the date of the application and the acceptance date. The insured is not entitled to benefits until the membership premium is paid. Any person who knowingly and with intent to defraud and insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature of Employee: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I authorize any insurance company, hospital, medical or medically related facility, physician or other medical practitioner or any other organization, institution or person who has any past or present information about me, or my dependents' physical or mental health, including substance use or abuse, to release that information to Welborn Health Plans, its business associates and its underwriters. I understand that the privacy of any medical information released pursuant to this authorization will be maintained in accordance with applicable law. This authorization will be valid for twenty-four (24) months from the date of my signature. A photocopy of this authorization shall be as valid as the original. I am aware that I may obtain a copy of this authorization by a written request to Welborn Health Plans.

I understand that I have the right to revoke this authorization at any time by writing to WHP at the following address: 101 S.E. Third Street, Evansville, IN 47708. I understand that such revocation will not affect the uses and disclosures of such information which have occurred in reliance upon my authorization before WHP's receipt of a written revocation.

I understand that signing this authorization is voluntary and treatment will not be conditioned upon my signing this authorization. However, enrollment in WHP may be denied should I fail to sign this authorization.

Signature of Employee: _____ **Date:** _____

The answers provided in this questionnaire are considered Private Health Information (PHI) and are protected by the Health Insurance Portability & Accountability Act (HIPAA). It will be used by the insurance carrier to determine the appropriate risk and premium and will not be shared with any other party other than the carrier and insurance agent.