



Group Health Questionnaire

Group Name _____

- 1. Do you know of any employee or dependent that is:
a. Currently pregnant or have reason to suspect you might be pregnant? Circle YES or NO
b. Financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? Circle YES or NO
2. Do you know of any employee or dependent that, in the past 24 months, has been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery that has not been completed? Circle YES or NO
3. Do you know of any employee or dependent that, within the past 24 months, has had a health related condition for which they have not sought medical advice or treatment? Circle YES or NO
4. Do you know of any employee or dependent that, within the past five years, has received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of the following conditions? Circle YES or NO and circle all that apply
a. Arthritis, Reumatologic disorder or any disease or disorder of the joints, bones, muscles or back
b. AIDS or tested positive for HIV
c. Asthma, Emphysema, COPD, TB, or any other disease or disorder of the respiratory system
d. Cardiovascular disease or disorder of the heart, arteries, blood vessels or blood
e. Cancer or tumor
f. Chemical dependency, drug or alcohol abuse, or any other mental health disease or disorder
g. Crohn's disease, ulcerative colitis, hepatitis or any other disorder of the liver, stomach, colon or intestines
h. Diabetes or any other disorder of the pancreas
i. Immune system disease or disorder
j. Kidney disease or disorder
k. Neurological system disorder
l. Stroke

If you answered yes to any of the above questions, please explain including: Name of person, date of condition, conditions treatments, and medications, expected future treatments and other information to better understand your needs.

Table with 4 columns: Name of person, Date of incident or of last treatment, Explain condition, Explain treatment including any expected future treatment including medications (use back of page if you need more room)

I certify that the above information is true to the best of my knowledge. I understand that this may become part of an application for health insurance and is subject to the Utah code regarding such applications.

Signature _____ Date _____