

Small Group Medical Insurance Pre-Screen Employee Information Form

In order for Insurance Carriers to properly rate your Group Medical Insurance plan, we must obtain health history information on you and your dependents (if requesting dependent coverage). We ask that you complete this information form which includes health questions. Your information will remain confidential and only the individuals performing the medical underwriting will see your health information. This allows our company to obtain quotes that will be more accurate. Please complete this form completely and as accurately as possible.

Company Name:

Employee Information

/ /	M	F	/ /	/ /	Single	Married
Name: First / Last	Gender		Date of Birth	Date of Hire	Status	
Are You Currently Covered by the (Employer Name) Group Medical Plan?				Y N	Are You or Your Dependents covered by another Group, Individual or Government Medical Plan?	
Are Your Dependents Currently Covered by the Group Medical Plan?				Y N		
Do You Intend to Enroll Yourself and/or Your Eligible Dependents or Decline Coverage In the Medical Plan?			Employee Only	Enroll Decline	Spouse	Enroll Decline
					Children	Enroll Decline

!!! If you are covering your Child(ren), Please complete the following section !!!

	First Name	Last Name	Date of Birth	Height	Weight		First Name	Last Name	Date of Birth	Height	Weight
Child						Child					
Child						Child					

If you are declining coverage, you will not be eligible to enroll until your next open enrollment period, unless you have a qualifying event, such as loss of other coverage.

If you are declining, skip the next section and sign and date at the bottom of the form.

Medical History Information

Employee's Height		EE's Weight		Spouse's Height		Spouse's Weight		Spouse's Date Of Birth	/ /
1. Is anyone who will be covered under the medical plan planning or is scheduled for hospitalization, surgery, medical treatment, therapy, counseling, medical tests, currently taking medications or is anyone pregnant?								Yes No	
2. In the past 5 years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.)									
Cancer		Alcohol / Drug Use		Arthritis / Bone / Joint / Muscle		Skin / Eye / Ear / Nose / Throat			
Tumor		Liver / Hepatitis		Allergy / Asthma / Respiratory		Kidney / Bladder / Urinary			
Infertility		Heart / Circulatory		Digestive / Intestinal / Eating		High Blood Pressure			
Endocrine		Mental / Nervous		Stroke / Neurological / Nervous System		Last Reading and Date			
Diabetes - Last HbA1c Reading and Date					AIDS / Infection with HIV virus or Other Immune Disorder				

If you checked any of the boxes above please complete the details below. If you need more room please attach another form.

Name:		Date diagnosed / treated		Duration of illness or condition	
Diagnosis	Type of Treatment / Name of all Medications / Dosage				
Any current symptoms or problems					
Name and phone number of doctors, hospitals or other providers					

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Employee's Signature



Date