

Section 4. Health questions

Answer these questions only if you're applying for underwritten coverage.

Do not answer these questions for an Open Enrollment or Guaranteed Issue application. If any health questions are answered "yes" in section 4, except for question 12, the applicant(s) will not qualify for this insurance with us.

	Applicant:	
	A	B
1. Are you dependent on a wheelchair or any motorized mobility device?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. leukemia, lymphoma, multiple myeloma, cirrhosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia multiple sclerosis, muscular dystrophy, cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?		
A. that requires use of insulin	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. with history of heart attack or stroke (at any time)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. internal cancer, melanoma, Hodgkin's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. hepatitis, disorder of the pancreas	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 4. Health questions *continued*

	Applicant:	
	A	B
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. myasthenia gravis, systemic lupus or connective tissue disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. any lung or respiratory disorder and currently use tobacco products	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. had a seizure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 60%;"> Systolic is the upper number and diastolic is the bottom number of a blood pressure reading. </div>		
12. Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<div style="border: 1px solid black; padding: 10px; margin: 10px auto; width: 60%;"> Answering "yes" to question 12 will not disqualify you for this insurance. </div>		

13. Applicant A

Applicant B

Height (feet and inches)

Weight (pounds)

Height (feet and inches)

Weight (pounds)

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Section 5. Health history - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section.**

Applicant A

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

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Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

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List the name of any medications you are taking and the reason why, if known.

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Use an additional sheet of paper if needed for explanation.

Section 5. Health history - applicant B

Applicant B

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

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Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

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List the name of any medications you are taking and the reason why, if known.

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Section 6. Physician information - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section.**

Applicant A primary physician

Phone

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Physician's office name

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City

State

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Have you seen any additional physicians other than those listed above in the past 24 months?

Yes No

Section 6. Physician information - applicant B

Applicant B primary physician

Phone

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Physician's office name

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City

State

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Specialist seen in the past 24 months

Specialty

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Reason for seeing (*diagnosis*)

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Have you seen any additional physicians other than those listed above in the past 24 months?

Yes No