



Small Group Health Questionnaire

GROUP NAME No Place Like Home

An Independent Licensee of the BlueCross BlueShield Association

(To be completed by Eligible Employees of groups with 2 - 25 participating employees)

REFERENCE #	Last Name	First Name	MI	Social Security #	Date of Birth	Gender		Height Feet/Inches	Weight Pounds	Used Tobacco products within past 12 months?	
						Male	Female			Yes	No
[1] Employee	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
[2] Spouse	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
[3] Dependent	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
[4] Dependent	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
[5] Dependent	_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Employee Home Zip Code _____

PART A HAS ANYONE ENROLLING FOR COVERAGE BEEN DIAGNOSED, TREATED OR HAD TREATMENT RECOMMENDED FOR ANY OF THE MEDICAL CONDITIONS LISTED BELOW WITHIN THE LAST 5 YEARS UNLESS OTHERWISE INDICATED? COMPLETE A DIAGNOSIS DETAIL FOR ANY "YES" ANSWER IN PART A

Please answer ALL questions on this form. Questions should be answered only for the employee, spouse and dependents enrolling for coverage. Answers should include personal medical information only. Do not include genetic testing/genetic screening or information regarding the enrollee's family medical history

Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	1. Cancer - Melanoma or Breast Cancer within the past 10 years or any other type of cancer within the past 5 years including Leukemia, Lymphoma, Hodgkin's, or Malignant Cysts
<input type="checkbox"/>	<input type="checkbox"/>	2. Heart / Circulatory - Heart Attack, Congestive Heart Failure, Angioplasty, Stroke, Aneurysm, Angina, or Serious Heart Disorder
<input type="checkbox"/>	<input type="checkbox"/>	3. Blood - Hemophilia, Von Willebrand Disease, Sickle Cell Anemia, or other serious condition of the blood
<input type="checkbox"/>	<input type="checkbox"/>	4. Reproductive Systems / Congenital - Cervical Dysplasia, Sexually Transmitted Disease, High Risk Maternity (Currently Pregnant <17 or >41 Years of Age, Gestational Diabetic, Toxemia, Requiring Hospitalization, or Multiple Fetus), Premature Infant born within the last 24 months , Congenital Disease or Birth Defect requiring ongoing treatment
<input type="checkbox"/>	<input type="checkbox"/>	5. Diabetes - taking Insulin or more than one Medication or with either High Blood Pressure, Eye Disorder, Neuropathy (Numbness, Tingling or Pain to Hands or Feet), Kidney or Heart Disorder
<input type="checkbox"/>	<input type="checkbox"/>	6. Intestinal / Endocrine - Ulcerative Colitis / Proctitis, Crohn's Disease, Chronic Pancreatitis, Cirrhosis of the Liver, Hepatitis (B, C, or E)
<input type="checkbox"/>	<input type="checkbox"/>	7. Brain / Neurological - Alzheimer's, Cerebral Palsy, Epilepsy, Multiple Sclerosis, Muscular Dystrophy, Paralysis, Parkinson's Disease, Seizures, Lou Gehrig Disease or other serious related disorder
<input type="checkbox"/>	<input type="checkbox"/>	8. Lung / Respiratory - Cystic Fibrosis, Emphysema, Tuberculosis, Sleep Apnea, RSV, Hospitalized for Asthma, Bronchitis, or Pneumonia, or other severe lung / respiratory condition
<input type="checkbox"/>	<input type="checkbox"/>	9. Urinary / Kidney - (excluding Kidney Stones), Renal Failure / Dialysis, an Ostomy, or other Serious Urinary / Kidney Disorder
<input type="checkbox"/>	<input type="checkbox"/>	10. Immune System - HIV Positive, AIDS, Discoid or Systemic Lupus, Connective Tissue Disorder, or other Immune System disorder within Lifetime
<input type="checkbox"/>	<input type="checkbox"/>	11. Skeletal / Muscle / Skin - Rheumatoid Arthritis, Sciatica, or Arthritis requiring walker/wheelchair, surgery, or prosthesis, Severe Burn, Bulging/Herniated Disc, or other Serious Related Disorder
<input type="checkbox"/>	<input type="checkbox"/>	12. Behavioral Health - Alcohol or Drug Abuse Treatment, Hospitalization or Outpatient Therapy for a Nervous & Mental or Eating Disorder
<input type="checkbox"/>	<input type="checkbox"/>	13. Transplants - Organ or Bone Marrow Transplant (or awaiting or discussed such transplant) within Lifetime
<input type="checkbox"/>	<input type="checkbox"/>	14. Within the last 12 months has any applicant: Been advised to have surgery, testing, or special immunizations but not yet done? Been hospitalized or had claims more than \$25,000 for any condition not listed on this application? Taken or been prescribed 3 or more different medications for any one/single condition? Been on Disability from work more than two weeks?

PART B Use the reference number (top left of page) associated with the person listed for each "Yes" answer when completing condition details below.

Yes	No	Has anyone enrolling for coverage seen a Physician within the past 12 months? List details below.
<input type="checkbox"/>	<input type="checkbox"/>	Does anyone enrolling for coverage have any of the following conditions? Circle each one that applies and list details below

a. Currently Pregnant b. Tumors c. Back Disorder d. Infertility e. Arthritis f. Gout g. Cysts h. Fibroids i. Menstrual Disorder j. Endometriosis k. Anemia l. Goiter

Ref. #	First Name	Condition	Diagnosis including Treatment, Prescription Drugs, or Reason for Visit	Date of Initial Diagnosis	Date of Last Treatment	Complete?
						Yes No
1	Example-Employee Name	a.	Example - currently 6 months pregnant, no problems, see doctor twice a month, prenatal vitamins	11/1/2006	3/30/2007	<input type="checkbox"/> <input checked="" type="checkbox"/>
						<input type="checkbox"/> <input type="checkbox"/>
						<input type="checkbox"/> <input type="checkbox"/>
						<input type="checkbox"/> <input type="checkbox"/>
						<input type="checkbox"/> <input type="checkbox"/>

PART C For everyone enrolling, list all medications, other than those disclosed in Part B, currently taking or taken within the last 12 months. Please include the reason for taking and frequency of use.

Ref. #	First Name	Medications, Reason for Taking, and Frequency of Use
2	Example-Spouse Name	Example- Glucophage XR, diabetes, once a day / atenolol, hbp, once a day / lmitrex, migraines, as needed / Allegra OTC, allergies, as needec

Please Read Carefully and Sign Below: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Small Group Health Questionnaire 5-1-2010 GINA Updated Employee Signature: _____ Date: _____