

Information Sheet

Business Name: _____

Address: _____

Business Phone: _____

Cell Phone: _____

Nature of Business: _____

FEIN or SSN: _____

Type of Business:

Sole Proprietor

Partnership

Corporation

LLC

Years in Business: _____

Employee Medical Questionnaire

Employee Name: _____ Height: _____ Weight: _____

Male: _____ Female: _____

Home Address: _____

Date of Birth: _____

Tobacco Usage: Yes _____ No _____

Who will be covered (Circle One)?

Employee Only/ Employee & Spouse/Employee & Children/Family (Spouse & Children)

Has anyone to be covered under this plan been treated for or diagnosed within the last 5 years as having a disorder or disease as follows: (Please specify employee, spouse, or child for any Yes answers)

1. High blood pressure, pain or tightness in the chest, heart disorder, or overweight?

Yes _____ No _____

2. Arthritis, Cancer, Diabetes, Organ Transplants, or disorders of the following nature?

Kidneys	Nervous System
Intestinal System	Respiratory System
Muscular System	Back

Yes _____ No _____

3. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immune Deficiency (HIV)?

Yes _____ No _____

4. Other diseases or illnesses not mentioned above?

Yes _____ No _____

Please explain:

5. Other diseases or illness accumulating more than \$5,000 in claims in the last year?

Yes _____ No _____

If "YES" to any of the previous questions, please complete the information below:

Question Number	Medical Expenses in the Last 12 Months	Specific Diagnosis	Prognosis	Medication

Please list all current prescription medications for anyone that will be covered by this plan:
