PacifiCare®

Medically Underwritten Individual Plan Health Questionnaire

Applicant Type:

☐ Business Group of One

☐ Individual

Employer________________________________

Occupation________________________________

Date________________________________

Name of Applicant________________________________
First Initial Last

Address of Applicant________________________________
Street City State Zip

Phone # of Applicant________(______)____________________(______)____________________
Home Business

Print name of applicant and each member of the family to be covered	Sex M/F	Age	Last Complete Physical Mo/Yr	Height	Weight	Previous PacifiCare member? Mo/Yr	Smoker Yes	Smoker No
Applicant 00								
Spouse 02								
Dependent 03								
Dependent 04								
Dependent 05								
Dependent 06								

A. Has any proposed covered person ever had, been treated, diagnosed or had any indication of the following conditions? (CHECK EACH CONDITION EITHER "YES" OR "NO".) Provide Details Under Section C.

	YES	NO
1. Breast Disease	☐	☐
2. Heart Disease	☐	☐
3. Heart Murmur	☐	☐
4. Heart Abnormality	☐	☐
5. Chest Pains	☐	☐
6. High Blood Pressure	☐	☐
7. Stroke	☐	☐
8. Heart Attack	☐	☐
9. Circulatory Disease	☐	☐
10. Paralysis	☐	☐
11. Vein Disorder	☐	☐
12. Cancer (give source)	☐	☐
13. Anemia	☐	☐
14. Blood Disorder	☐	☐
15. Lupus	☐	☐
16. Leukemia	☐	☐
17. Tumors (benign or malignant)	☐	☐
18. Skin Lesions	☐	☐
19. Asthma	☐	☐
20. Emphysema	☐	☐
21. Chronic Bronchitis	☐	☐
22. Chronic Cough	☐	☐
23. Allergies (includes injection)	☐	☐
24. Bladder Disorder	☐	☐
25. Prostate Disorder	☐	☐
26. Gallbladder Disease	☐	☐
27. Liver Disease	☐	☐

	YES	NO
28. Spleen Disease	☐	☐
29. Stomach Disorder	☐	☐
30. Intestinal Disorder	☐	☐
31. Colon Disorder	☐	☐
32. Ulcers	☐	☐
33. Kidney Disorder (stones)	☐	☐
34. Rectal Disease	☐	☐
35. Hemorrhoids	☐	☐
36. Infertility	☐	☐
37. Venereal Disease	☐	☐
38. Inguinal Hernia	☐	☐
39. Hiatal Hernia	☐	☐
40. Enlarged Glands (last 12 months)	☐	☐
41. Thyroid Disorder	☐	☐
42. Goiter	☐	☐
43. Chronic Fatigue	☐	☐
44. Hypoglycemia	☐	☐
45. Diabetes (insulin dependent)	☐	☐
46. Diabetes (other)	☐	☐
47. Alcoholism	☐	☐
48. Drug Abuse	☐	☐
49. Bells Palsy	☐	☐
50. Numbness of a body part	☐	☐
51. Pain, previously diagnosed	☐	☐
52. Back Problems	☐	☐
53. Seizures (date of last seizure __|__|__)	☐	☐
54. Fainting Spells	☐	☐

	YES	NO
55. Dizziness	☐	☐
56. Epilepsy	☐	☐
57. Depression	☐	☐
58. Brain Damage	☐	☐
59. Head Injury	☐	☐
60. Chronic Migraines	☐	☐
61. Chronic Headaches	☐	☐
62. Bone Fractures	☐	☐

	YES	NO
63. Arthritis	☐	☐
64. Gout	☐	☐
65. Bursitis	☐	☐
66. Extremity Amputation	☐	☐
67. Eye Disorder	☐	☐
68. Cataracts	☐	☐
69. Ear Disorder	☐	☐
70. Throat Disorder	☐	☐
71. Nose Disorder	☐	☐
72. Other Problems (not mentioned above-list under Section C.)	☐	☐

B. Has any proposed covered person:

	YES	NO
1. Ever been treated or diagnosed for Acquired Immune Deficiency Syndrome (AIDS), or received a positive result to a diagnostic test designed to screen for AIDS?	☐	☐
2. Ever had any surgical operations?	☐	☐
3. Ever been advised to have any diagnostic test, hospitalization, treatment, or surgery which was not completed?	☐	☐
4. Ever taken drugs regularly, other than drugs prescribed by an attending physician or been treated for use of drugs? If yes, include dates of most recent use.______	☐	☐
5. Ever had a military deferment, rejection, or discharge because of a physical or mental condition?	☐	☐

C. IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS (SECTION A1-A72 AND B1-B-5), COMPLETE THIS SECTION, GIVE COMPLETE DETAILS - ADD ADDITIONAL PAGE IF YOU NEED MORE SPACE.

Name of Proposed Covered Person	Diagnosis, Operations, or Checkup	Date Started	Date Stopped	Dates In Hosp.	Doctor's Name & Address

D. Has any proposed covered person seen a physician for any reason in the past year? YES ☐ NO ☐
If yes, list below:

Name of Proposed Covered Person	Physician	Date	Reason & Treatment or Recommendation

E. Is any proposed covered person currently taking any medications on a regular basis? YES ☐ NO ☐
If yes, list below:

Name of Proposed Covered Person	Diagnosis	Name of Medication & Dosage	Prescribing Physician

F. Does any proposed covered person engage in any hazardous sports, e.g. hang gliding, auto racing, rock climbing, etc.? If yes, explain. YES ☐ NO ☐

G. Is any proposed covered person confined to a hospital on this date? If yes, explain. YES ☐ NO ☐

H. Has any proposed covered person ever been declined coverage by PacifiCare or any health, accident, or life insurance company, or have you ever been offered any insurance policy different from that applied for or at an increased rate? If yes, explain. YES ☐ NO ☐

I. During the past year, has any proposed covered person's weight:

	YES	NO
a. Increased by 10 lbs. or more	☐	☐
b. Decreased by 10 lbs. or more	☐	☐

Name__________ Reason for change__________

FOR WOMEN ONLY - PLEASE COMPLETE

A. Is any proposed covered person pregnant at this time? YES ☐ NO ☐

If no, date of proposed covered persons' last menstrual period if applicable.

Name	Month	Day	Year
Name	Month	Day	Year
Name	Month	Day	Year

YES ☐ NO ☐

B. Has any proposed covered person ever had any abnormality of female organs or abnormal menstrual periods or any unexplained vaginal bleeding? If yes, explain. YES ☐ NO ☐

C. Has any proposed covered person ever had an abnormal pap smear? If yes, explain.

Please turn page

Acknowledgements and Agreements

I/we understand and agree that I/we must notify PacifiCare in writing of any impairment, disease or change in my/our health status which occurs or is diagnosed between the date of application and the date of acceptance. PacifiCare shall have the right to request and review additional information regarding any change in my/our health status.

Such review may affect the offering of PacifiCare Coverage

I/we represent to the best of my/our knowledge and belief that all statements and answers on this application and any medical records are complete and true. The medical exam and or physician's medical records shall become part of the application. **I/we understand and agree that the falsity of any answer, statement or omission of pertinent medical information will deny me or us the right to obtain coverage under PacifiCare.**

I/we understand that PacifiCare will request proof of good health from me/us and a complete physical examination may be needed. The cost for this and/or any other cost to obtain medical information will be paid by me or us.

I/we understand and agree that: 1. the covered benefits shall not take effect unless the application has been accepted and approved by PacifiCare and until the Effective Date of the Policy; and 2. oral statements between the Account Executive/Producer and myself/ourselves are not binding on PacifiCare unless accepted by PacifiCare in writing. PacifiCare shall not be liable for any expenses incurred by any individual prior to the effective date of coverage.

Business Group of One
Additional Information

Acceptance of coverage for a Business Group of One is not guaranteed and is subject to medical underwriting, except that the Basic and Standard Health Benefit plans are available on a guaranteed issues basis if application is made to PacifiCare within the thirty-one days following the applicant's date of birth. This will be considered the applicant's open enrollment period.

A Business Group of One may apply for any PacifiCare Small Group plan at any time with the submission of medical records that include a medical history and physical examination. Review of the application and acceptance or denial of coverage may take up to four to six weeks.

ANY MISREPRESENTATION AS TO THE PRESENCE OR SEVERITY OF ANY PRE-EXISTING CONDITION, IMPAIRMENT OR DISEASE MAY VOID YOUR MEMBERSHIP BENEFITS RETROACTIVELY TO THE DATE YOUR PACIFICARE BENEFITS BEGAN.

IMPORTANT - ALL QUESTIONS MUST BE ANSWERED, APPLICATIONS WILL BE RETURNED IF ANY QUESTION IS NOT ANSWERED.

Dated at: City ______________________ State ______________

Month ________________ Day ___________ Year __________

Signature ____
Applicant (for and on behalf of the above named members)

Signature ____
Spouse, Parent (of minor), next of kin or legal representative

PacifiCare®

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Cypress, CA 90630

Internal Use Only
☐ Open Enrollment Period
☐ Non-Open Enrollment Period