



Health Status Questionnaire

Does not apply to Basic or Standard plans

Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options, Inc.

Please complete this questionnaire for yourself and all dependents. Attach additional sheets for additional dependents.

Group Name: _____		Employee Name: _____		Phone: () _____		Social Security # _____ - _____ - _____	
Name	Employee	Spouse	Dependent	Dependent	Dependent	Dependent	Dependent
Birth Date							
Sex							
Height							
Weight							
1. Do you smoke or use tobacco regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No							
2. What medications do you take? Drug Name / Strength / Quantity / Per Month							
3. In the past 5 years, have you had problems with your heart, liver, kidney, lung, or nervous system?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis							
Date of Onset	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Type of Treatment							
Date of Last Treatment							
Current Status							
4. In the past 5 years, have you had rheumatoid arthritis, lupus, multiple sclerosis, AIDS/HIV, leukemia, diabetes, lymphoma, cancer, mental health disorders?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis							
Date of Onset	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Type of Treatment							
Date of Last Treatment							
Current Status							
5. In the past 5 years, have you been hospitalized?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diagnosis							
Date of Onset	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Type of Treatment							
Date of Last Treatment							
Current Status							
6. In the past 5 years, have you been treated for alcohol or drug abuse?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Which							
Type of Treatment							
Date of Last Treatment	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Current Status							
7. Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No							
Due Date	/ /	/ /	/ /	/ /	/ /	/ /	/ /
Complications							
8. How many times have you been to an emergency room in the past 2 years?							
# of Times							
Reason							
9. Have you been advised to have any treatment or surgery that has not yet been performed?							
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please describe:							
Any knowing misrepresentation of the presence or severity of any health condition, impairment, or disease and/or failure to notify RMHP of any medical condition, impairment, disease, or change in any applicant's health status that occurs or is diagnosed between the date of application and the effective date of coverage could result in retroactive termination of coverage.							
I attest that the above information is true. Subscriber Signature						Date	

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CONFIDENTIAL

To be opened by
Rocky Mountain Health Plans

In order to keep confidential
please fold and seal and submit to your
personnel staff along with your Enrollment Form

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