



Individual Health Questionnaire

Please print or type in black ink only. See instructions before completing this form. Retain a copy of this application for your records.

TO BE COMPLETED BY GROUP (for new or enrolling employee)		
Company Name / DBA	Hire Date (mm/dd/yyyy)	Enrollment Date Requested:

You must complete this form in its entirety in in order for you or your dependents to be covered under the health insurance plan. If you are waiving coverage for yourself or your dependents, it must be clearly indicated on this form. If you do not complete this form in its entirety for yourself or your dependents at least 5 business days prior to the effective date, you or your dependents may not be eligible for coverage until the next open enrollment period.

TO BE COMPLETED BY EMPLOYEE (if applying or waiving coverage)

NEW ENROLLMENT or WAIVER, please check one:	
<input type="checkbox"/> New hire <input type="checkbox"/> Re-hire <input type="checkbox"/> Open enrollment <input type="checkbox"/> New group	<input type="checkbox"/> Other coverage loss, Qualifying event: _____ date (mm/dd/yy) _____ <input type="checkbox"/> COBRA <input type="checkbox"/> Waiver of Coverage (complete section B.)

BENEFIT PLAN: Plan Name:

A. EMPLOYEE (Primary Applicant)

Name (Last, First, MI):					
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Social Security Number:	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy):	Average number of hours worked per week?	Height (ft,in):	Weight (lbs):
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Home Street Address (other than P.O. Box)	City	State	Zip
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Home Phone: () Cell Phone: ()	Work Phone: () Best Time to Call:	E-mail Address:
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Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Check One: <input type="checkbox"/> Full-Time <input type="checkbox"/> Seasonal <input type="checkbox"/> Part-Time <input type="checkbox"/> Temporary <input type="checkbox"/> COBRA <input type="checkbox"/> Cal-COBRA <input type="checkbox"/> Retiree	(PCP is not a required field) Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Are you an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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B. Employee's Name: _____	Employee's date of birth (mm/dd/yyyy): _____
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REASON FOR WAIVING:

- ☐ Have not met employer's requirements
- ☐ Insured under spouse
- ☐ Other (please provide reason):

C. DEPENDENT APPLICANTS For additional Dependents, attach a separate page with Employee's Name listed.			
1. <input type="checkbox"/> Add <input type="checkbox"/> Delete	Name (Last, First, M) _____		Date of Marriage, Divorce, or Separation: _____
	<input type="checkbox"/> Spouse or <input type="checkbox"/> Domestic Partner Birth Date (mm/dd/yyyy): _____ <input type="checkbox"/> Male <input type="checkbox"/> Female		
Social Security Number: _____	Height (ft/ in) : _____ Weight: 130 (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2. <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted / Other: _____		<input type="checkbox"/> Different Last Name _____ <input type="checkbox"/> Disabled: _____ <input type="checkbox"/> Lives at Another Address Location: _____	
	Child Name: (Last, First, MI)			
Social Security Number: _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy): _____	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted / Other: _____		<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address: location _____ <input type="checkbox"/> Disabled: _____	
	Child Name: (Last, First, MI)			
Social Security Number: _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy): _____	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted / Other: _____		<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address: location _____ <input type="checkbox"/> Disabled: _____	
	Child Name: (Last, First, MI)			
Social Security Number: _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy): _____	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. <input type="checkbox"/> Add <input type="checkbox"/> Delete	<input type="checkbox"/> Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted / Other: _____		<input type="checkbox"/> Different Last Name <input type="checkbox"/> Lives at another address: location _____ <input type="checkbox"/> Disabled: _____	
	Child Name: (Last, First, MI)			
Social Security Number: _____	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date (mm/dd/yyyy): _____	Height (ft/ in) : _____ Weight: (lbs.): _____	Primary Care Physician (PCP) Name: _____ PCP Provider Number: _____ Is he/she an Existing Patient? <input type="checkbox"/> Yes <input type="checkbox"/> No

D. SHORT FORM – Health Questions

Please answer the following questions and provide details to ALL “YES” answers for all Applicants in the space indicated below.

In the past five (5) years, has any Applicant seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests, or been advised to have treatment or surgery for any of the following:

a.	Heart attack, brain tumor, stroke, heart disease or heart problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	g.	Brain disorder, bipolar, psychotic disorder, seizures, epilepsy, or any other mental or emotional condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b.	Cancer, tumor, lymphoma, or any type of transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	h.	Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c.	Emphysema or COPD?	<input type="checkbox"/> Yes <input type="checkbox"/> No	i.	Hemophilia, blood disorder, anemia, circulatory disorder, or any blood or circulatory condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d.	Diabetes, endocrine or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+?	<input type="checkbox"/> Yes <input type="checkbox"/> No	j.	Currently pregnant, premature delivery or multiple birth ? pending due date? _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
e.	Alcoholism, drug, or any substance abuse, or tobacco use?	<input type="checkbox"/> Yes <input type="checkbox"/> No	k.	Any surgery, tests, drugs, doctor visit or hospitalization current, advised, planned or recommended?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f.	Back or joint problems, rheumatoid arthritis, fibromyalgia, paralysis or any musculoskeletal condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	l.	Any other medical condition(s) not listed in previous questions?, and disability?, or taking any prescription drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section D. (cont.) Please provide FULL DETAILS, including the name of the Applicant(s), condition(s), treatment(s), medication(s), and dates. If more space is needed, please attach a separate page with details, and include the Employee's name and Applicant's name.

Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?

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	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking Medication? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?

F. APPLICATION Authorization, Signature, and Health Plan Arbitration Agreement:

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. I understand that the following parties may need to provide or collect information on me or my Dependent Applicants: National General Benefits Solutions and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my Dependent Applicants to provide all such information as requested by National General Benefits Solutions or its Business Associates or Agents.

I understand that this Authorization may be needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to National General Benefits Solutions.

I acknowledge that I have been advised that (1) fraudulent statements or misrepresentation of material facts may result in retroactive termination of your coverage and (2) knowing and willful misstatements in this individual health questionnaire may represent a criminal violation of 18 US Code Section 1347 (punishable by up to 10 years in prison).

Employee/Primary Applicant Signature: _____ **Date:** _____

When complete, please submit this questionnaire via email to Assochealthbenefits@ngic.com or via fax to (855) 718-4697