National General
Benefits Solutions

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:
Convo Communications, LLC	06/09/2014	06/01/2015

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:**

- ❑ New hire
- ❑ Re-hire
- ☒ Open enrollment
- ❑ New group
- ❑ Other coverage loss, Qualifying event:_____date (mm/dd/yy)_____
- ❑ COBRA
- ❑ Waiver of Coverage (complete section B.)

BENEFIT PLAN: Plan Name: NG5

A. EMPLOYEE (Primary Applicant)

Name (Last, First, MI): Colayori, Kailea, C

Social Security Number:	Gender	Birth Date (mm/dd/yyyy):	Average number of hours worked per week?	Height (ft,in):	Weight (lbs):
067-74-7688	❑M ☒F	04/29/1986	40	5'9	289lbs

Home Street Address (other than P.O. Box)	City	State	Zip
835 Woodbine Avenue	Rochester	NY	14619

Home Phone:	Work Phone:	E-mail Address:
( )	( )	ConvoKailea@gmail.com
Cell Phone: ( ) 585-233-3047	Best Time to Call:	

Status:	Check One:	
☒ Single ❑ Married	☒ Full-Time	❑ Seasonal
❑ Divorced ❑ Widowed	❑ Part-Time	❑ Temporary
❑ Legally Separated	❑ COBRA	❑ Cal-COBRA
	❑ Retiree	

(PCP is not a required field)

Primary Care Physician (PCP) Name: _____

PCP Provider Number: _____

Are you an Existing Patient? ☐ Yes ☐ No

B. Employee's Name: _____ Employee's date of birth (mm/dd/yyyy):_____

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. ❑ Add ❑ Delete

Name (Last, First, M)_____

❑**Spouse or** ❑ **Domestic Partner** Birth Date (mm/dd/yyyy): _____
❑ Male ❑ Female

Date of Marriage, Divorce, or Separation:

Social Security Number:

Height
(ft/ in) : _____

Weight:
(lbs.): _____

Primary Care Physician (PCP) Name:
_____
PCP Provider Number:
_____
Is he/she an Existing Patient? ☐ Yes ☐ No

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2. ❑ Add ❑ Delete

❑**Child** ❑ **Step-Child**
❑ **Adopted / Other:**

❑Different Last Name _____ ❑ Disabled:
❑ Lives at Another Address Location:_____

Child Name: (Last, First, MI)

Social Security Number:

Gender
❑M
❑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? ☐ Yes ☐ No

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3. ❑ Add ❑ Delete

❑**Child** ❑ **Step-Child**
❑ **Adopted / Other:**

❑Different Last Name ❑ Lives at another address: location _____
❑ Disabled: _____

Child Name: (Last, First, MI)

Social Security Number:

Gender
❑M
❑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? ☐ Yes ☐ No

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4. ❑ Add ❑ Delete

❑**Child** ❑ **Step-Child**
❑ **Adopted / Other:**

❑Different Last Name ❑ Lives at another address: location _____
❑ Disabled: _____

Child Name: (Last, First, MI)

Social Security Number:

Gender
❑M
❑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? ☐ Yes ☐ No

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5. ❑ Add ❑ Delete

❑**Child** ❑ **Step-Child**
❑ **Adopted / Other:**

❑Different Last Name ❑ Lives at another address: location _____
❑ Disabled: _____

Child Name: (Last, First, MI)

Social Security Number:

Gender
❑M
❑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? ☐ Yes ☐ 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?	☐ Yes ☑ No	**g.**	Brain disorder, bipolar, psychotic disorder, seizures, epilepsy, or any other mental or emotional condition?	☐ Yes ☑ No
b.	Cancer, tumor, lymphoma, or any type of transplant?	☐ Yes ☑ No	**h.**	Kidney failure, dialysis, or disorder of the liver, stomach, pancreas, colon or bladder?	☐ Yes ☑ No
c.	Emphysema or COPD?	☐ Yes ☑ No	**i.**	Hemophilia, blood disorder, anemia, circulatory disorder, or any blood or circulatory condition?	☐ Yes ☑ No
d.	Diabetes, endocrine or pituitary disorder, growth disorder, lupus, MS, AIDS, or HIV+?	☐ Yes ☑ No	**j.**	Currently pregnant, premature delivery or multiple birth ? pending due date? ___________	☐ Yes ☑ No
e.	Alcoholism, drug, or any substance abuse, or tobacco use?	☐ Yes ☑ No	**k.**	Any surgery, tests, drugs, doctor visit or hospitalization current, advised, planned or recommended?	☐ Yes ☑ No
f.	Back or joint problems, rheumatoid arthritis, fibromyalgia, paralysis or any musculoskeletal condition?	☐ Yes ☑ No	**l.**	Any other medical condition(s) not listed in previous questions?, and disability?, or taking any prescription drugs?	☐ Yes ☑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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? ❑ Yes ❑ No	Taking Medication? ❑ Yes ❑ 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 Benfits 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: Kailea C Colayori ______________________ **Date:** 05/19/2015 ______________

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