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		06/01/2015

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): Worthingtin, Kathryn, A.

Social Security Number:	Gender	Birth Date (mm/dd/yyyy):	Average number of hours worked per week?	Height (ft,in):	Weight (lbs):
053-70-6844	☐M ☑F	04/17/1984	32	5' 7"	345

Home Street Address (other than P.O. Box)	City	State	Zip
3976 Walworth-Ontartio Rd	Walworth	NY	14568

Home Phone: ( )	Work Phone: ( )	E-mail Address:
585-507-1584	Best Time to Call:	Kathryn.a.worthingtin@gmail.com
Cell Phone: ( )		

Status:
- ☐ Single
- ☑ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Legally Separated

Check One:
- ☑ Full-Time
- ☐ Part-Time
- ☐ COBRA
- ☐ Retiree
- ☐ Seasonal
- ☐ Temporary
- ☐ Cal-COBRA

(PCP is not a required field)

Primary Care Physician (PCP) Name: Dr. Eddie Laroche

PCP Provider Number: 315-986-1336

Are you an Existing Patient? ☑ Yes ☐ No

B. Employee's Name: Kathryn A Worthingtin **Employee's date of birth (mm/dd/yyyy):** 04/17/1984

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) Worthingtin, William, G

☒ Spouse or ☐ Domestic Partner ☒ Male ☐ Female

Birth Date (mm/dd/yyyy) 08/04/1979

Date of Marriage, Divorce, or Separation: 10/11/08

Social Security Number: 094-76-7041

Height (ft/ in) : 6'1"

Weight: (lbs.): 279

Primary Care Physician (PCP) Name: Dr. Eddie Laroche

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) Worthingtin, Jacob, G

Social Security Number: 053-02-0286

Gender ☒ M ☐ F

Birth Date (mm/dd/yyyy): 04/04/2010

Height (ft/ in) : 4'1"

Weight: (lbs.): 58 lbs

Primary Care Physician (PCP) Name: Dr. Eric Socha

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) Worthingtin, Annabelle

Social Security Number: 803-09-8147

Gender ☐ M ☒ F

Birth Date (mm/dd/yyyy): 07/20/2012

Height (ft/ in) : 3'2"

Weight: (lbs.): 40

Primary Care Physician (PCP) Name: Dr. Eric Socha

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?	Taking Medication?
A	William Worthington	High Blood Pressure	2011 ish		☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed? Medication			**Medication Names:** Losartan Potassium		**Surgery or Hospitalization?** none
D	Kathryn Worthington	Gestational Diabetes	4/12	7/20/12 after Birth	☐ Yes ☒ No	☐ Yes ☒ No
	Treatment Given or Needed? Change Diet + insulin			**Medication Names:** insulin Don't remember names		**Surgery or Hospitalization?** NA
F	William	Arthritis	5/2015		none yet ☐ Yes ☐ No	☐ Yes ☒ No
	Treatment Given or Needed? Has not gone for follow up appt. yet. Just had PCP appt. and it looks like Arthritis dont know type yet.			**Medication Names:** none yet		**Surgery or Hospitalization?** NA

Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
K	William		5/2015		☐ Yes ☐ No	☐ Yes ☑ No
	Treatment Given or Needed? Reffered to Rheumatologist			Medication Names:		Surgery or Hospitalization?
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
I	Kathryn				☑ Yes ☐ No	☑ Yes ☐ No
	Treatment Given or Needed? Working with Dr. on weight loss			Medication Names: - Metphormen - Phentromine		Surgery or Hospitalization?
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
					☐ Yes ☐ No	☐ 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: Kathryn A. Worth **Date:** 5/20/15

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