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	4/22/13	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: N/A date (mm/dd/yy) ~~5/26/15~~
- ☐ COBRA
- ☐ Waiver of Coverage (complete section B.)

BENEFIT PLAN: Plan Name: NG5

A. EMPLOYEE (Primary Applicant)

Name (Last, First, MI): WELD, DALLES B. JANILYNN

Social Security Number:	Gender	Birth Date (mm/dd/yyyy):	Average number of hours worked per week?	Height (ft,in):	Weight (lbs):
346-68-3855	☐M ☒F	02/21/1967	40	5'5"	253

Home Street Address (other than P.O. Box)	City	State	Zip
15310 Cypress Pointe Dr.	Fort Wayne	IN	46818

Home Phone:	Work Phone:	E-mail Address:
(260) 625-4131	(605) 595-5109	codame1@gmail.com
Cell Phone: (605) 595-5109	**Best Time to Call:** 6p-10p (EST)	

Status:	Check One:		*(PCP is not a required field)*
☐ Single ☒ Married	☒ Full-Time	☐ Seasonal	Primary Care Physician (PCP) Name: Brooke Bohnstedt, APN
☐ Divorced ☐ Widowed	☐ Part-Time	☐ Temporary	PCP Provider Number: _____
☐ Legally Separated	☐ COBRA	☐ Cal-COBRA	Are you an Existing Patient? ☒ Yes ☐ No
	☐ Retiree		

B. Employee's Name: B. JANILYNN WELD-DALLES **Employee's date of birth (mm/dd/yyyy):** 02/21/1967

REASON FOR WAIVING:

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

C. DEPENDENT APPLICANTS For additional Dependents, attach a separate page with Employee's Name listed.

1. ☒ Add ☐ Delete

Name (Last, First, M): DALLES, JOHN, R.

☒ Spouse or ☐ Domestic Partner ☐ Male ☒ Female

Birth Date (mm/dd/yyyy): 03/14/59

Date of Marriage, Divorce, or Separation: 12/18/95

Social Security Number: 398-78-2798

Height (ft/ in): 6'1"

Weight (lbs.): 300 lbs

Primary Care Physician (PCP) Name: BROOKE BOHNSTEDT

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 N/A ☐ Disabled:

☐ Lives at Another Address Location:

Child Name: (Last, First, MI)

DALLES, MERCEDES

Social Security Number: 387-17-2465

Gender ☐ M ☒ F

Birth Date (mm/dd/yyyy): 03/20/1997

Height (ft/ in): 5'7"

Weight (lbs.): 258

Primary Care Physician (PCP) Name: Dr. Collins-Austin

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 N/A

☐ Disabled:

Child Name: (Last, First, MI)

DALLES, MYLES

Social Security Number: 397-21-7428

Gender ☒ M ☐ F

Birth Date (mm/dd/yyyy): 11/9/2001

Height (ft/ in): 6'1"

Weight (lbs.): 165

Primary Care Physician (PCP) Name: Dr. Collins-Austin

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: N/A

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: N/A

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? N/A	☐ 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?
	Mercedes Dalles	Hypothyroidism	[redacted] 2011	N/A	☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed? Medication Maintenence Controlled			Medication Names: Levothyroxine (Synthroid)		Surgery or Hospitalization? N/A
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
	Mercedes Dalles	Acid Reflux	2014	N/A	☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed? Medication Maintenence Controlled			Medication Names: Ranitidine		Surgery or Hospitalization? N/A
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
	John Dalles	High Blood Pressure	2009	N/A	☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed? Medication maintained controlled			Medication Names: Amlodipine		Surgery or Hospitalization? N/A

B. JANILYNN WELD-DALLES
Hypothyroidism - 2008 - Tx: YES - RX: YES
Medication Controlled
Levothyroxine

High Blood Pressure - 2014 - Tx: YES - Rx: YES
Medication controlled
Lisinopril

~~PREDNISONE~~
Chemical Imbalance - 1992 - Tx: YES - RX - YES
Medication balanced
FLUOXETINE

S.A.D. & ADHD; CHEMICAL IMBALANCE - 2004 - TX: YES - RX: YES
MEDICATION CONTROLLED
BUPROPRION XL

HYPERINSOMNIAC, RLS, NARCOLEPSY & ADHD ~~PANIC~~ - 2003 - TX: YES - RX: YES
SLEEPWALKING

MEDICATION COMBO BALANCED
① NUVIGIL ② DEXEDRIN ③ ~~KLONOPIN~~ PRAMIPEXOLE

-Low ~~B12~~ VITAMAN D3, HEALTHY HEART TX - 2004 - TX: YES - RX: NO
MEDICATION CONTROLLED (OTC)
① OMEGA 3 ② ~~K2~~ VITAMAN D3 ③ ASPIRIN

Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
	JOHN DALLES	High Cholesterol	2014	N/A	☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
	Medication Controlled			Atorvastatin		N/A
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
	JOHN DALLES	Hypothyroidism	2009	N/A	☒ Yes ☐ No	☒ Yes ☐ No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
	Medication Controlled			Levothyroxine		N/A
Question Letter:	Applicant Name:	Condition/Diagnosis:	Date of Onset:	Date of Recovery?	Still Under Treatment?	Taking Medication?
	JOHN DALLES	Depression	2006	N/A	☐ Yes ☒ No	☐ Yes ☒ No
	Treatment Given or Needed?			Medication Names:		Surgery or Hospitalization?
	ceased medication			Zoloft		N/A

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: _____ **Date:** 5/26/2015

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