

Employee Health Questionnaire

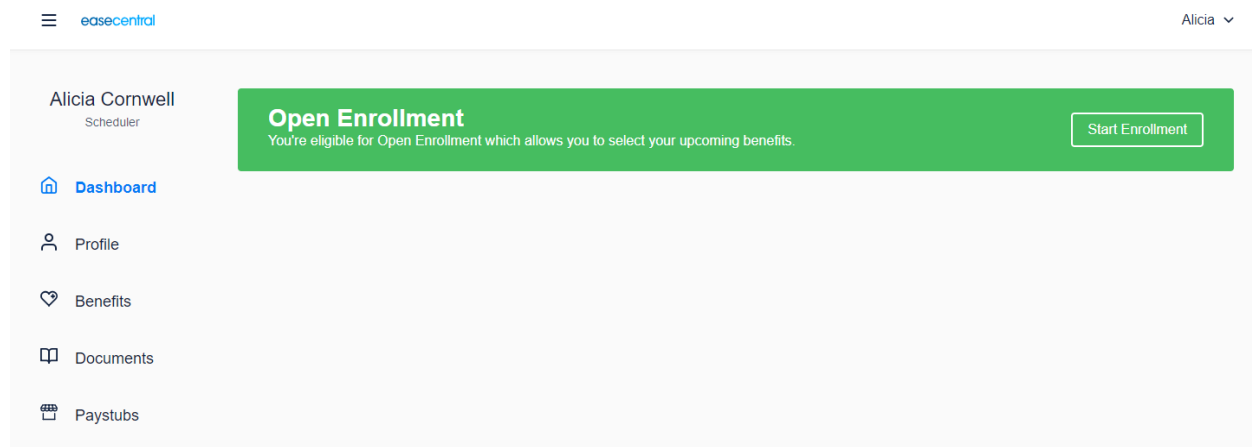
When employers are looking to offer new self-funded medical plans, carriers often require that employees complete health-risk assessment forms or questionnaires that ask employees to report health histories, family patterns of disease, and lifestyle choices such as tobacco use. Employees are prompted to complete the required health questions on carrier-specific health questionnaire/risk assessment forms for themselves and their dependents.

Notes:

- If you have previously completed the same health questions and it has been more than 90 days, Ease requires you to answer the questions again.
 - If you answer yes to any health questions, you see your previous answers.

Procedure:

From Your Ease Dashboard:



1. Click **Start Enrollment**.

- 1 Overview
- 2 Profile
- 3 Dependents
- 4 Documents
- 5 Medicare
- 6 Benefits
- Medical Underwriting
- 7 Coverage
- 8 Health
- 9 Summary
- 10 Sign Forms
- 11 Finish

Medical Underwriting Plan

Specify your coverage

Select Enrolled or Waived for each eligible member below.

Iylee Beanblossom Employee	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bobby Beanblossom Spouse	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Kathy Beanblossom Child	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Randy Beanblossom Child	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Ricky Beanblossom Child	Enrolled	<input checked="" type="checkbox"/>	<input type="checkbox"/>

2. Check **Enrolled** for **Medical Underwriting Plan** for employee and all eligible dependents.
 - The employee is prompted to answer a series of questions relating to his/her health and the health of dependents eligible for medical benefits.

- 1 Overview
- 2 Profile
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- 7 Coverage
- 8 **Health**
- Conditions
- Questions
- Height & Weight
- Details
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Health Information

Has lylee Beanblossom, Bobby Beanblossom, Kathy Beanblossom, Randy Beanblossom, or Ricky Beanblossom ever been diagnosed, treated, or are currently being treated, for any of the following conditions?

Heart/Circulatory

Please Select ☒ ☐

Such as: Abnormal heart catheterization, Aneurysm, Angina, Angioplasty, Angioplasty/Stent, Arrhythmia / Irregular heartbeat, Arteriosclerosis, Artery or blood vessel disease, Atherosclerosis, Atrial Fibrillation, Blood clots, Blood vessels, Bypass, Cardiomyopathy, Cardiovascular, Cartoid Artery disease / Stenosis, Cerebrovascular, Chest pain, Circulatory disorder, Congestive heart failure, Coronary artery disease, Defibrillator use, Edema, Elevated cholesterol levels, Elevated triglycerides, Endocarditis, Heart attack, Heart disease or disorder, Heart Failure, Heart murmur, Heart regurgitation, Heart surgery, Hemorrhage, High blood pressure, Hyperlipemia, Hypertension, Irregular heartbeat, Low blood pressure, Mitral valve prolapse, Pacemaker, Peripheral artery disease, Phlebitis, Shortness of breath, Skin ulcerations, Stent, Stress test (electrodiogram or echocardiogram), Stroke, Tachycardia, Temporal arteritis, Thrombophlebitis, Transient ischemic attack, Valvular heart disease, Varicose veins, Vascular disorder, Other heart/circulatory disorder

Blood

Please Select ☒ ☐

Such as: Albumin, Anemia, Bleeding disorder, Blood disorder, Bubonic plague, Hemophilia, Malaria, Polycythemia, Sickle Cell, Thalassemia, Thrombocytopenia, Other blood disorder

Lung/Respiratory

Please Select ☒ ☐

Such as: Adenoids, Allergies, Asthma, Chronic bronchitis, Chronic obstructive pulmonary disease (COPD), Cystic fibrosis, Decompression or compressed air sequelae, Emphysema, Hay fever, Lung disease caused by inhalation of asbestos particles, Lung disorder, Lung fibrosis caused by inhalation of dust containing silica, Mouth patches, Persistent cough, Pleurisy, Pneumonia, Positive TB skin test, Pulmonary fibrosis, Pulmonary hypertension, Respiratory disorder, Sleep Apnea, Tuberculosis, Other lung/respiratory disorder

3. If Yes is marked for any of these conditions, enter additional required health information.

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Heart/Circulatory

Yes ☒ X


- | | | |
|---|---|---|
| <input type="checkbox"/> Abnormal heart catheterization | <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Angioplasty/Stent | <input type="checkbox"/> Arrhythmia / Irregular heartbeat |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Artery or blood vessel disease | <input type="checkbox"/> Atherosclerosis |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Blood clots | <input type="checkbox"/> Blood vessels |
| <input type="checkbox"/> Bypass | <input type="checkbox"/> Cardiomyopathy | <input type="checkbox"/> Cardiovascular |
| <input type="checkbox"/> Carotid Artery disease / Stenosis | <input type="checkbox"/> Cerebrovascular | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Circulatory disorder | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Coronary artery disease |
| <input type="checkbox"/> Defibrillator use | <input type="checkbox"/> Edema | <input type="checkbox"/> Elevated cholesterol levels |
| <input type="checkbox"/> Elevated triglycerides | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Heart disease or disorder | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Heart murmur |
| <input type="checkbox"/> Heart regurgitation | <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Hemorrhage |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Hyperlipemia | <input checked="" type="checkbox"/> Hypertension |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Peripheral artery disease | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Skin ulcerations | <input type="checkbox"/> Stent |
| <input type="checkbox"/> Stress test (electrodiagram or echocardiogram) | <input type="checkbox"/> Stroke | <input type="checkbox"/> Tachycardia |
| <input type="checkbox"/> Temporal arteritis | <input type="checkbox"/> Thrombophlebitis | <input type="checkbox"/> Transient ischemic attack |
| <input type="checkbox"/> Valvular heart disease | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Vascular disorder |
| <input type="checkbox"/> Other heart/circulatory disorder | | |


4. Once forms are generated, type your full name as it appears in **Create your signature**.

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Create your signature

Start by typing your full name as it appears below.


Alicia Cornwell

 **SHA-256 with RSA Encryption**
I understand this is a legal representation of my signature.

Next

5. Click **Next**.

Create your signature

Some carriers require a hand-drawn signature. Please draw your signature in the box below.



A blue ink signature is drawn on a white rectangular box. The signature consists of two large loops followed by a long horizontal stroke. A dashed line is visible at the bottom of the box. A small 'x' is located at the bottom left corner of the box. The word 'clear' is written in blue text at the top right corner of the box.



SHA-256 with RSA Encryption

I understand this is a legal representation of my signature.

Next

6. Using mouse or touch screen, add hand-drawn signature.
7. Click **Next**.

Review & Sign Forms

Please review all of the information presented for completeness and accuracy.

When you are ready, sign each section by tapping on the green signature prompts. If at any time you feel like you need to make changes, you can go back to enrollment by selecting 'Back' in the top navigation bar. For additional help, please reach out to your HR administrator.



SHA-256 with RSA Encryption

I understand this is a legal representation of my signature.

Next

8. Review forms for completeness and accuracy.
9. Click **Next**.

Section 8 - Disclosure of personal and health information

At Blue Shield of California, we understand the importance of keeping your personal information private, and we take our obligation to do so very seriously. Blue Shield protects the privacy and security of the personal information that we maintain, use, and disclose for purposes of administering your Blue Shield coverage.

Blue Shield obtains personal information about you and/or your covered dependents, including health and/or financial information, from you, at your direction, and/or with your permission. We are also permitted by federal and state law to obtain your personal information from other sources, including, for example, from your healthcare provider, insurer, insurance support organization, health plan, or insurance agent. We use and disclose your personal information to administer your Blue Shield coverage and as otherwise permitted or required by law. In doing so, we may disclose your personal information to others including, for example, a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Blue Shield will not disclose your personal information without your authorization except as permitted or required by law.

Blue Shield is required to provide you with a Notice of Privacy Practices ("Notice") that describes your privacy rights, our obligations to protect your privacy, and how we use and disclose your personal information with and without your specific authorization. When we use or disclose your personal information, we are bound by the terms of the Notice, which applies to all records that we create, obtain, and/or maintain that contain your personal information. You will receive our Notice when you enroll for Blue Shield coverage. You may also obtain a copy of our Notice by calling the customer service number on your Blue Shield member ID card or by visiting our website at blueshieldca.com/bzca/documents/about-blue-shield/privacy.

Acknowledgement and signature

I acknowledge and agree: All information I have provided on this enrollment form is correct and true to the best of my knowledge and belief. I understand that it is the basis on which I am enrolled under the plan. I understand that if I have committed fraud or made an intentional misrepresentation of any material fact in conjunction with this enrollment, Blue Shield may remove me from the following remedies: coverage may be cancelled, or the applicable premium may be adjusted, or following notice, coverage may be rescinded. I further authorize my employer to deduct from my earnings the contribution (if any) required toward the cost of this plan.

☒ I understand that coverage does not become effective until this and my employer's application have been approved by Blue Shield of California.

Signature of employee

Alicia Cornwell

Print employee name

Date

All pages of this form are necessary to process your enrollment.
Missing information may delay processing.

10. Tap each green signature prompt as they appear.

Back

0 signatures remaining (14 pages)

Finish Signing

Evaluating unlicensed DynamicPDF feature. DynamicPDF.com [4.0.5.1]

IMPORTANT: CAREFULLY REVIEW YOUR FORMS

The purpose of this online tool is to help you easily complete several different forms. It is important that you review each of these forms to make sure that they are completed accurately.

11. Once complete, click **Finish Signing**.

- Note 0 signatures remaining (x pages)

- 1 Profile
- 2 Dependents
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- 4 Benefits
- 5 Coverage
- 6 Summary
- 7 Sign Forms
- 8 **Finish**

Congratulations! Your enrollment elections have been submitted for review.

How was your enrollment experience?



Tell us about your experience

 Need Help? [Get Support](#)

Submit Feedback


12. Note **100% Complete**.

Congratulations! Your enrollment elections have been submitted for review.

How was your enrollment experience?



What a great experience! I love Ease.

 Need Help? [Get Support](#)

Submit Feedback

13. Optional: add star rating and comments, then click **Submit Feedback**.

- 1 Profile
- 2 Dependents
- 3 Documents
- 4 Medicare
- 5 Benefits
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- 8 Sign Forms
- 9 **Finish**

Congratulations! Your enrollment elections have been submitted for review.

[Need Help?](#) [Get support](#)

Thank You for your feedback! Click Finish above to go to your dashboard

14. Otherwise, click **Finish**.

End of Procedure