



MEDICAL QUESTIONNAIRE for LATE ENROLLEES

Applicant: _____	SSN#: _____
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All of the following questions must be answered in ink in the employee's own handwriting for each person applying for coverage. Use a separate sheet, if necessary; sign, date, and attach to the questionnaire. YOUR COVERAGE CANNOT BE DECLINED BASED ON HEALTH STATUS RELATED FACTORS. However, INTENTIONAL MISREPRESENTATION OF MATERIAL FACT MAY RESULT IN TERMINATION OR RESCISSION OF COVERAGE.

1. Has any person to be insured ever been declined, surcharged, rescinded or restricted for the issuance of life, health or accident insurance? Member: _____ Reason: _____ Yes No
2. Has any person to be insured ever been insured with Arkansas Blue Cross and Blue Shield or Health Advantage? Member: _____ Yes No
3. In the past 10 years, has any person to be insured ever had or been advised to have treatment, diagnosis or care for:
 (Circle each applicable condition and give details in the Additional Medical Information Section below.)
 - a. Chest pain, heart attack, high blood pressure, coronary artery disease, stroke, blood clots, or any other disorder of the heart or circulatory system? Yes No
 - b. Diabetes or high blood sugar? Yes No
 - c. Shortness of breath, asthma, allergies, TB (Tuberculosis), emphysema, Chronic Obstructive Pulmonary Disease, sleep apnea, or other respiratory disorder? Yes No
 - d. Chronic headache, fainting, dizziness, seizure, epilepsy, convulsion, fatigue, spinal cord or brain injury or paralysis, or any neuromuscular disorder? Yes No
 - e. Anxiety, panic attack, depression, mental disease, nervous disorder, eating disorder or attempted suicide? Yes No
 - f. Drug abuse, alcohol abuse, illegal substance abuse, DUI or DWI? Yes No
 - g. AIDS, HIV positive status or any immunodeficiency disorder? Yes No
 - h. Cancer, malignancy, tumor or growth? Yes No
 - i. (Male or Female) reproductive organs, abnormal bleeding, disorder of the breast, infertility, endometriosis or pelvic pain? Yes No
 - j. Any recurrent pain, including pain of knee, back, neck, head or limbs? Yes No
 - k. Arthritis or other chronic pain, disease or disorder of the muscle, bones, connective tissue or joints? Yes No
 - l. Disorder or disease of gall bladder, esophagus, liver, stomach, intestine or digestive system, including hepatitis, ulcers, colitis, etc.? Yes No
 - m. Disorder or disease of the kidney, bladder, prostate, rectum or any disorder of the urinary or renal system? Yes No
 - n. Disease or disorder of the blood, glands (including thyroid), skin or lymphatic system? Yes No
 - o. Disease or disorder of the ears, nose, throat or sinuses; glaucoma, cataract or other eye disorder? Yes No
 - p. Any physical or mental problem, condition or disease NOT listed above? Yes No
4. Has any person to be insured been injured in any kind of accident within the last 5 years? Yes No
5. Has any person to be insured ever been to see, or been advised to see a surgeon, chiropractor, counselor, psychiatrist, social worker, pain specialist, physical therapist, speech therapist, rehabilitation therapist, occupational therapist, oncologist, endocrinologist or other health care provider within the past 10 years? (Circle each provider and give details in the Additional Medical Information Section below.) Yes No
6. In the past 10 years, has any person to be insured ever been hospitalized, received hospital services or had surgery? If "yes" please list all hospitalizations, services and surgeries in the Additional Medical Information Section. Yes No

ADDITIONAL MEDICAL INFORMATION List below full details to questions answered "Yes." Use a separate sheet if necessary.

Question Number	Person Treated	Name of Disorder & Type of Treatment	Date Occurred	Date Recovered	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	

MEDICAL QUESTIONNAIRE (continued)

7. Has any person to be insured ever used a prosthetic device? Yes No
 If "yes", what type? _____ When? _____
8. Has any person to be insured used tobacco in the last 12 months? Yes No
 Member _____ What type? _____
9. Is any person currently pregnant? Due date: _____ Yes No
10. Has any person to be insured been prescribed or taken any prescription medication for more than a total of 30 days in the past 2 years? If "yes" list full details below. (Use separate sheet if necessary. Sign, date and attach to this Application.) Yes No

Prescription Information

Person Treated	Name of Drug	Dosage	Condition or Illness	Start Date	Stop Date	Complete Name & Address of Physician

11. In the past 2 years, has any person to be insured discontinued or failed to take medication prescribed by a physician? If "yes" describe in space below. (Use separate sheet if necessary. Sign, date and attach to this Application.) Yes No

SIGNATURES (PLEASE READ BEFORE SIGNING IN INK.)

I understand that the benefits for which I (we) will be eligible are those described in the USABLE Life group policies with my employer as may from time to time be amended. I understand that coverage will not become effective before the approved effective date. In addition to other exclusions and limitations, NO USABLE LIFE BENEFITS WILL BE AVAILABLE FOR UP TO 12 MONTHS FROM MY EFFECTIVE DATE OR THE FIRST DAY OF MY WAITING PERIOD. IF I AM A LATE ENROLLEE THE PERIOD OF PRE-EXISTING CONDITION EXCLUSION WILL BE 18 MONTHS FROM THE DATE I SUBMIT THIS APPLICATION

In signing below, I represent that the statements and answers given in this application are true, complete and correctly recorded. If my application is accepted relying on my representations on this document, any coverage that may be issued to me shall be invalid if based on false information. I understand that any material misrepresentation, omission or intentional fraudulent statement may result in cancellation or rescission of any coverage issued in reliance thereon, and that USABLE Life may recover any monies and damages incidental and consequential that result.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

 Print Name of Applicant

 Signature of Applicant

 Date

 Print Employer/Group Representative*

 Signature Employer/Group Representative*

 Date

*Required for new hires and additions only.