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Name Registered with Medicare Last	First	M.I.	Social Security Number - -
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7. HEALTH INFORMATION - Explain any "yes" answers below.

In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Do not complete this section if applying during open enrollment or the guaranteed issue period.

Have you ever had, been treated or diagnosed for:

- | | | | |
|---|-----|----|---|
| <table border="0"> <tr> <td style="text-align: center;">Yes</td> <td style="text-align: center;">No</td> </tr> </table> | Yes | No | <ol style="list-style-type: none"> 1. <input type="checkbox"/> <input type="checkbox"/> Anemia, leukemia or any blood disorder 2. <input type="checkbox"/> <input type="checkbox"/> Any disability, injury or bodily deformity 3. <input type="checkbox"/> <input type="checkbox"/> Any physical impairment or condition requiring periodic or long-term follow-up such as cerebral palsy, multiple sclerosis, muscular dystrophy, etc. 4. <input type="checkbox"/> <input type="checkbox"/> Arthritis or rheumatism 5. <input type="checkbox"/> <input type="checkbox"/> Asthma, emphysema, COPD, any lung disease, sleep apnea or use of a CPAP machine 6. <input type="checkbox"/> <input type="checkbox"/> Cancer, tumor or any abnormal growth (malignant or non-malignant) 7. <input type="checkbox"/> <input type="checkbox"/> Diabetes or sugar in urine. If yes, a current Hgb A1C level from a medical professional is required. State name of insulin below. 8. <input type="checkbox"/> <input type="checkbox"/> Seizures, epilepsy, loss of consciousness or fainting spells 9. <input type="checkbox"/> <input type="checkbox"/> Goiter or thyroid disorder 10. <input type="checkbox"/> <input type="checkbox"/> Hernia, hemorrhoids or varicose veins 11. <input type="checkbox"/> <input type="checkbox"/> Heart attack, angina or other heart disorders 12. <input type="checkbox"/> <input type="checkbox"/> Stroke, paralysis or circulatory disorders 13. <input type="checkbox"/> <input type="checkbox"/> Hypertension or high blood pressure. If yes, a current blood pressure reading from a medical professional is required. 14. <input type="checkbox"/> <input type="checkbox"/> Liver or gallbladder disorder, jaundice or gallstones 15. <input type="checkbox"/> <input type="checkbox"/> Kidney stone, kidney, bladder or prostate disorder 16. <input type="checkbox"/> <input type="checkbox"/> Endometriosis, fibroids, prolapse, abnormal female bleeding, menstrual disorder or abnormal pap smear 17. <input type="checkbox"/> <input type="checkbox"/> Infertility (male or female) 18. <input type="checkbox"/> <input type="checkbox"/> Psychiatric, nervous or mental disorder, depression or attention deficit disorder 19. <input type="checkbox"/> <input type="checkbox"/> Recurrent headaches or migraines 20. <input type="checkbox"/> <input type="checkbox"/> Chemical dependency or alcoholism or been treated for the use of alcohol or drugs 21. <input type="checkbox"/> <input type="checkbox"/> Ulcers, ulcerative colitis, Crohn's disease, stomach or intestinal disorders 22. <input type="checkbox"/> <input type="checkbox"/> Back disorders, chronic low back pain or disk disorders 23. <input type="checkbox"/> <input type="checkbox"/> Cataract, visual loss, ear infection or ear disorder 24. <input type="checkbox"/> <input type="checkbox"/> Temporomandibular or Craniomandibular Joint Treatment (TMJ or CMJ) 25. <input type="checkbox"/> <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) 26. <input type="checkbox"/> <input type="checkbox"/> Any other condition, disorder, illness or disease for which further diagnostic tests, consultation, observation, treatment, surgery or hospitalization has been recommended 27. <input type="checkbox"/> <input type="checkbox"/> Have you been treated by a chiropractor in the last year? If yes, state frequency of treatments and date of last treatment below. 28. <input type="checkbox"/> <input type="checkbox"/> Are you taking medicine prescribed by a physician? If yes, list medication(s) below. 29. <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? 30. <input type="checkbox"/> <input type="checkbox"/> Have you had a vaginal or Cesarean Section delivery within the past six months? If yes, provide the date of postnatal visit for vaginal delivery or date of Cesarean Section delivery below. 31. <input type="checkbox"/> <input type="checkbox"/> Are you currently a resident in a custodial center or nursing home? 32. <input type="checkbox"/> <input type="checkbox"/> Have you been ill, injured or consulted with a health care provider for any other reason within the past five years? |
| Yes | No | | |

Explain "yes" answers to any of the above questions. Give complete details. Also indicate your current physician. Use extra paper if necessary.

Question Number	Diagnosis, Treatment or Reason for Medical Attention	Attending Physician Name and Address	Current Physician Name and Address	Date of Onset	Days in Hospital	Recovery Date	Workers' Comp. (Y/N)	No-Fault (Y/N)