

HEALTH HISTORY QUESTIONNAIRE

For quoting purposes, please answer the following health questions for ALL persons to be covered under the policy. E-Mail your responses to Kevin Kinard at hlthsolutions@prodigy.net or fax to (269) 385-2762.

Any questions, call (269) 385-2762.

Zip Code _____

#1. Age_____ Sex____ Height____ Weight_____ Smoker__(Y/N)
(list for each family member)

#2. Dependent Status - circle one (single, ind./spouse, ind./children, family)

#3. Within last 12 months have you or dependents had any medical expenses that were equal or greater than \$10,000? (Y/N) If yes, please indicate amount and describe condition causing claim.

#4. Other than above, are you or your dependents pregnant? (Y/N)
disabled? (Y/N)

#5. In last 5 years have you or your dependents had surgery, been hospitalized or consulted with a doctor or been advised to receive medical treatment? (Y/N) If yes, describe on back of this sheet date of diagnosis, nature of illness or injury and current or future treatment.

#6. In last 5 years have you or dependents received treatment or been diagnosed with any of the following? (check all that apply and describe on back of this sheet date of diagnosis, nature of illness or injury and current or future treatment.)

Cancer	Bone Disorder	Tumors
Joint Disorder	Heart Condition	Urinary Disorder
High Blood Pressure	Respiratory Disorder	Stroke
Mental Disorder	Liver Disorder	Nervous Disorder
Kidney Disorder	Diabetes	Muscle Disorder
Hepatitis	Multiple Sclerosis	AIDS
ARC	Any Immune Disorder	Other (not listed)

#6. List all prescription medications (and define condition medication is intended to treat) that you or your dependents are currently taking or have taken in the last 12 months.