

# Medical Associates Health Plans

1605 Associates Drive, Dubuque, Iowa 52002  
 (563) 556-8070 or 1-800-747-8900

## Health Questionnaire/Evidence of Insurability

| Please Print Clearly and Complete <u>All</u> Information |         |      | Date of Birth | Soc. Security # | Sex | Height | Weight |
|--|---------|------|---------------|-----------------|-----|--------|--------|
| (Last)   | (First) | (MI) |               |                 |     |        |        |
| Applicant  |         |      | / /           |                 |     |        |        |
| Spouse   |         |      | / /           |                 |     |        |        |
| Dependents   |         |      | / /           |                 |     |        |        |
|  |         |      | / /           |                 |     |        |        |
|  |         |      | / /           |                 |     |        |        |
|  |         |      | / /           |                 |     |        |        |
|  |         |      | / /           |                 |     |        |        |
|  |         |      | / /           |                 |     |        |        |

Applicant's Occupation: \_\_\_\_\_

| <b>Health Questionnaire:</b> (Have you or any of your dependents listed above been diagnosed or treated by a physician for: Answer <i>Yes</i> or <i>No</i> -- If yes, explain under part 41 on reverse side) |   | Yes | No |
|--|---|-----|----|
| 1)   | Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV)? |     |    |
| 2)   | Alcohol/Drug Problems?  |     |    |
| 3)   | Back/Neck Problems?   |     |    |
| 4)   | Blood Disorders, Anemia, Hemophilia?  |     |    |
| 5)   | Breathing Problems, Asthma, Emphysema, Tuberculosis, Chronic Pulmonary Obstructive Disease?                 |     |    |
| 6)   | Cancer, Tumor, Cyst, Abnormal Growth, Leukemia?   |     |    |
| 7)   | Congenital Birth Defects?   |     |    |
| 8)   | Diabetes?   |     |    |
| 9)   | Ear Problems?   |     |    |
| 10)  | Eye Problems, Cataracts, Glaucoma?  |     |    |
| 11)  | Heart Trouble, Heart Attack, Heart Failure, Murmur, Rheumatic Fever?  |     |    |
| 12)  | High Blood Pressure?  |     |    |
| 13)  | Infertility?  |     |    |
| 14)  | Intestinal/Bowel Trouble, Ulcerative Colitis, Crohn's Disease, Hemorrhoids?                                 |     |    |
| 15)  | Joint/Muscle Disorder, Arthritis, Gout, Multiple Sclerosis?   |     |    |
| 16)  | Kidney, Bladder, Prostate Trouble?  |     |    |
| 17)  | Liver Trouble, Cirrhosis, Hepatitis, Jaundice, Gall Stones?   |     |    |
| 18)  | Memory Loss, Alzheimer's?   |     |    |
| 19)  | Menstrual Problems, Abnormal PAP Smear?   |     |    |

|            |   | Yes                | No   |   |
|------------|---|--------------------|--|---|
| 20)        | Mental/Nervous Condition, Eating Disorder, Attention Deficit?   |                    |  |   |
| 21)        | Mental Retardation?   |                    |  |   |
| 22)        | Migraines/Headache?   |                    |  |   |
| 23)        | Nervous System Disorder, Fainting, Dizziness, Stroke, Paralysis, Seizures, Epilepsy?  |                    |  |   |
| 24)        | Nose Problems, Hayfever, Allergies?   |                    |  |   |
| 25)        | Organ Transplants, Bone Marrow, Transplants?  |                    |  |   |
| 26)        | Sexually Transmitted Diseases, Syphilis, Gonorrhea, Herpes, Chlamydia?  |                    |  |   |
| 27)        | Skin Disorders?   |                    |  |   |
| 28)        | Stomach Disorder, Ulcer?  |                    |  |   |
| 29)        | Thyroid Disease, Goiter?  |                    |  |   |
| 30)        | Had an application for life or health insurance declined, modified or canceled?   |                    |  |   |
| 31)        | Currently taking medication prescribed by a physician for any reason? (list name and dose on back)  |                    |  |   |
| 32)        | Is any person named in the application pregnant?  |                    |  |   |
| 33)        | Did any pregnancies result in caesarean, ectopic or miscarriage?  |                    |  |   |
| 34)        | Were there any newborn complications?   |                    |  |   |
| 35)        | Does any person named in the application smoke cigarettes, cigars, pipe, or smokeless tobacco?  |                    |  |   |
| 36)        | Has any person named in this application had any illness or symptoms not previously referred to in this questionnaire?                        |                    |  |   |
| 37)        | Has any person named in this application been advised to have a surgical operation which has not yet been performed?                          |                    |  |   |
| 38)        | Has any person named in this application been under total disability or on a sick leave, medical leave of absence, or presently hospitalized? |                    |  |   |
| 39)        | Has any person named in this application been incapable of self sustaining employment due to a physical or mental condition?                  |                    |  |   |
| 40)        | Date of last physical: _____ Name of M.D. _____   |                    |  |   |
| 41)        | Write complete details applicable to the above questions:   |                    |  |   |
| Question # | Family Member Name  | Dates of Treatment | Give full details for each question answered "Yes", state the condition, duration & degree of recovery | Name and Address of Attending Physician |
|            |   |                    |  |   |
|            |   |                    |  |   |
|            |   |                    |  |   |
|            |   |                    |  |   |

I certify that the answers on this application are complete and true to the best of my knowledge. I understand that any misrepresentation or fraudulent statement, as to the presence or absence of preexisting medical conditions, impairments, disease or any other submissions will void membership and right to benefits. I understand that I must report any change in health status to Medical Associates Health Plans between the date of application and the acceptance date.

Date \_\_\_\_\_, 200\_\_\_\_ Applicant's Signature X \_\_\_\_\_  
 Applicant's Home Phone \_\_\_\_\_ Spouse's Signature X \_\_\_\_\_  
 Work Phone \_\_\_\_\_