PERSONAL HEALTH QUESTIONNAIRE
Self-Funded Medical Coverage 1-50 Enrolling Employees

EMPLOYER INFORMATION

Employer Name ____

Employer Address____________________City____________________State__________Zip__________County__________

EMPLOYEE INFORMATION

Last Name ____________________ First Name ____________________ Middle Initial __________

Address ____________________ City ____________________ State ________ Zip Code________ County __________

Email ____________________ Single Married

Phone Number: ☐ Home ☐ Cell ____________________ Date Employed Full-Time ____________________

Average Hours Worked Per Week ____________ Occupation ____________________ Independent Contractor? Yes No

EMPLOYEE WAIVER (Please complete if you are declining to apply medical coverage)

Please check all of the following that apply: I am declining to apply for medical coverage for Employee Spouse Child(ren)

Please state the reason for waiving to apply for coverage:__________________Qualifying Coverage______________________Other__________________

If I have waived applying for coverage for myself and/or my dependents (including my spouse) because of other health insurance coverage, I may in the future be able to enroll myself and/or my dependents in the coverage, provided that I request enrollment within 31 days after my other coverage ends because of involuntary loss of other coverage (divorce, death, legal separation, termination of employment, reduction in number of hours of employment). In addition, if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents, provided that I request enrollment within 31 days after the date of the event. I further understand that if I am considered a late enrollee, I may be declined from coverage or excluded from coverage for a period of time as defined in and where permitted by law, and I may be required to provide, where allowed by law, Medical History satisfactory to the Plan Sponsor or Administrator, for myself and/or my dependents.

FAMILY INFORMATION (ONLY for those applying for coverage)

First Name, M.I. (last name if different)	Date of Birth	Gender		Height	Weight (lbs)	Social Security Number	Primary Care Physician's Name
Self:		M	F				
Spouse:		M	F				
Child:		M	F				
Child:		M	F				
Child:		M	F				

COVERAGE INFORMATION

Coverage Type Selected: **Employee Only** **Family** **Employee & Spouse** **Employee & Child(ren)**

Name of Selected Medical Plan: ____

Change Coverage Request: **Marriage** **Divorce** **Adoption** **Court Order:**

Date of Event (you may be required to provide proof of the event): ____

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ELIGIBILITY / OTHER INSURANCE

Currently, are you working full-time? Yes No If no, explain ______________________________
(Full-Time Employee is defined as working minimum 24 hours per week. Seasonal, Part-Time and Temporary workers are not eligible.)

Y N Do you or any family members intend to keep other insurance coverage in addition to this coverage? If yes, list family members:

List the name of the other insurance company(ies) and the policy number(s):______________________________

List family members covered by Medicare and their effective date:______________________________

MEDICAL INFORMATION (REQUIRED)

1. Y N Are you or any dependent disabled, hospital confined, or pregnant? If pregnant, due date: _____/_____/_____

   If pregnant, are you expecting a multiple birth / having complications / planning a C-Section? Y N

2. Y N Are you or any eligible dependent receiving treatment; taking medication; receiving follow up care; scheduled for or awaiting results of any tests, biopsies, procedures or lab work; been advised to have a test; or been advised of a condition that will require attention in the next twenty-four (24) months?

3. Y N Have you or any eligible dependent used tobacco products in the past twelve (12) months?

4. Y N Have you or any eligible dependent ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please explain: ______________________________

5. In the past five (5) years, have you or any eligible dependent to be insured had any symptoms, diagnosis, consultation, testing, treatment, follow up care, or taken any medication or received counseling for:

a.	Yes	No	Cancer/Tumor	**g.**	Yes	No	Diabetes	**m.**	Yes	No	Infertility
b.	Yes	No	Kidney Disorder	**h.**	Yes	No	Liver Disorder/Hepatitis	**n.**	Yes	No	Respiratory/Lung
c.	Yes	No	Stroke	**i.**	Yes	No	Systemic Lupus/Multiple Sclerosis	**o.**	Yes	No	Organ/Tissue Transplants
d.	Yes	No	Immune System Disorder	**j.**	Yes	No	Mental/Nervous Disorders and/or Substance Abuse	**p.**	Yes	No	Neurological Disorder
e.	Yes	No	Arthritis/Back/Joint Disorder	**k.**	Yes	No	Heart/Blood/Hypertension Vascular Disorder	**q.**	Yes	No	Acquired Immune Deficiency Syndrome (AIDS)/AIDS Related Complex (ARC)/HIV
f.	Yes	No	Intestinal/Digestive Disorder	**l.**	Yes	No	Birth Defects/Congenital Disorder				

6. In the past five (5) years, have you or any eligible dependents:

   a. Been diagnosed with or treated for any condition(s) not identified above? Yes No

   b. Been advised of the necessity or possibility of any future hospitalizations, treatment, testing or surgery? Yes No

   c. Been receiving any medical care from a provider for any symptoms, not yet diagnosed? Yes No

Please provide details to "Yes" answers, including information regarding last doctor visit and/or physical examination and all medications taken: (attached extra pages if needed with signature and date)

Question/Letter	Name	Illness/Impairment	Treatment Dates	Medication/Treatment/Surgery/Physician
________	________	________	________	________
________	________	________	________	________

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Important Plan Information

Your employer has selected a health plan for you and your family that is self- insured and is provided by a multiple-employer welfare arrangement ("MEWA"). In the event the plan or MEWA does not ultimately pay medical expenses that are eligible for payment under the plan for any reason, your employer or you may be liable for the medical expenses.

You may obtain a copy of the Summary Plan Description ("SPD") by calling Aetna at 800-874-5552 or visiting the Associations' website at www.hbat.org.

EMPLOYEE AGREEMENT – SIGNATURE REQUIRED

*** TO BE A VALID APPLICATION, YOUR SIGNATURE AND THE DATE YOU SIGN IT ARE REQUIRED**

I understand that the previous answers will be relied upon by the Plan Sponsor in the issuance of coverage. I declare all statements contained in this entire form about me and my dependents are true and correct to the best of my knowledge and that no material information has been withheld or omitted. I understand that my intentional misrepresentation of a material fact or my failure to report information about me or my dependents may be used as the basis to rescind, terminate or modify coverage for me or my dependents. Rescind means that the coverage was never in effect. I understand that omission of medical conditions may result in the denial of coverage for claims related to the omitted medical conditions. I understand and agree that the Plan Sponsor is not bound by any statement made by or to any agent unless written herein. I agree that no coverage will be effective until the date specified by the Plan Sponsor. The actual effective date may not be the requested effective date. If I am now waiving medical benefits for myself and/or my dependents, I have read the entire Waiver provision, and understand the enrollment requirements if I make request for such benefits at a later date.

I authorize my employer to deduct the necessary contribution toward the benefits. I reserve the right to revoke this deduction authorization at any time upon my written notice. Benefits are effective only after approval by the Plan Sponsor or Administrator and satisfaction of any probationary period, if applicable.

Any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false information may be found guilty of fraud, which is a crime, in a court of law and may be subject to fines and confinement in prison. This will not be considered as a complete application unless all pages are attached and completed.

I understand that information on this form is valid for a maximum of 60 days from the date of signature.

Employee Signature X____**Date (required)** ____________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR ENROLLMENT – SIGNATURE REQUIRED

I also hereby authorize any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, pharmacy, pharmacy benefit manager, health plan, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the claims or third party administrator, any other excess loss insurance carrier designated by the Plan, or its legal representative, any and all such information as required for determination of eligibility for benefits. I also understand that my dependents of legal age, in order to be eligible for benefits, may be required to sign a similar release of medical records for the purpose of determining the accuracy of statements made by me on this application and for the ultimate determination of eligibility for benefits under the Plan. I understand I may request a copy of this authorization at any time. I understand any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I agree that a photographic copy of this authorization shall be as valid as the original. I understand the information obtained by use of this authorization may be used by the Plan Sponsor, claims or third party administrator, and any excess loss insurance carrier designated by the Plan to determine eligibility for health coverage, and eligibility for benefits under an existing plan, for myself and my dependents. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize. I also understand I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization. Should I refuse to sign this authorization, I understand it may affect my enrollment in the benefit plan. All pages must be attached and complete, including this authorization for the application to be considered complete. Incomplete applications may be rejected.

Employee Signature____**Date** ________________________

(Type name if this application is electronic and check here)