

APPLICATION FOR INSURANCE – HEALTH QUESTIONNAIRE

Please list below all persons applying for coverage:

Name (First, middle initial, last)	Date of Birth	Height	Weight	Name (First, middle initial, last)	Date of Birth	Height	Weight

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions.

1. Within the past 5 years, has anyone named in this application been counseled, consulted or treated for any of the following? (please check all conditions that apply):

CIRCULATORY SYSTEM

- a) heart disease or disorder Yes No
- b) stroke Yes No
- c) circulatory disorder Yes No
- d) chest pain Yes No
- e) high or low blood pressure Yes No
- f) elevated cholesterol and/or triglyceride levels Yes No
- g) anemia or blood disorder Yes No

DIGESTIVE SYSTEM

- a) ulcers Yes No
- b) stomach disorder Yes No
- c) liver/pancreas disorder Yes No
- d) gallbladder disorder Yes No
- e) intestinal disorder (ie. colitis, Crohn's disease) Yes No
- f) hernia Yes No
- g) rectal disorder Yes No

GENITOURINARY SYSTEM

- a) menstrual disorder Yes No
- b) genital disorder Yes No
- c) sexual dysfunction Yes No
- d) pregnancy complications (ie. premature birth, miscarriage, c-section) Yes No
- e) infertility Yes No
- f) urinary/tract/kidney/bladder disorder Yes No
- g) prostate disorder Yes No

NERVOUS SYSTEM

- a) epilepsy or other seizures Yes No
- b) headaches Yes No
- c) multiple sclerosis Yes No

CANCER

- a) cancer Yes No
- b) tumor Yes No
- c) abnormal growth Yes No
- d) carcinoma in situ Yes No

ENDOCRINE SYSTEM

- a) diabetes Yes No
- b) thyroid disorder Yes No
- c) adrenal disorder Yes No
- d) enlargement of the lymph-nodes Yes No
- e) connective tissue disorder Yes No

RESPIRATORY SYSTEM

- a) allergy(ies) Yes No
- b) asthmas Yes No
- c) emphysema Yes No
- d) sinus or nasal disorder Yes No
- e) lung disease or disorder Yes No
- f) shortness of breath Yes No

MUSCULAR or SKELETAL

- a) arthritis Yes No
- b) fibromyalgia Yes No
- c) back disorder Yes No
- d) joint disorder Yes No
- e) musculoskeletal disorder Yes No
- f) skin disorder Yes No
- g) chronic fatigue syndrome Yes No

EYE OR EAR

- a) eye disorder Yes No
- b) ear disorder Yes No

BEHAVIORAL HEALTH

- a) attention deficit disorder Yes No
- b) psychological disorder Yes No
- c) suicide attempt Yes No
- d) eating disorder Yes No

OTHER

- a) organ or other type of transplant/implant Yes No
- b) breast disorder Yes No
- c) lupus Yes No

2. Have you, or has any person to be insured:

- a) smoked or used any tobacco product in the past twelve months? Yes No
- b) used drugs other than prescribed by a physician? Yes No
- c) been advised to have treatment or counseling for alcohol or drug abuse? Yes No

3. Are you, or is any person to be insured, now pregnant? No Yes - expected delivery date _____
 Single birth Multiple birth, number _____

4. Within the past five years, has anyone named in this application had any other injury, illness or treatment for any condition not already listed; been hospitalized or scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application?
(We are not seeking the results of HIV Antibody test) Yes No

5a. In the space below, please list and provide complete details if you answered "Yes" to any of the above questions. (Attach additional pages as necessary and sign the additional pages.) (Be sure to note the most recent readings for anyone with High/Low Blood Pressure, Elevated Cholesterol or Triglyceride levels or Glaucoma. Be sure to indicate frequency of visits and date of last visit for anyone receiving Behavioral Health counseling.)

Question #	Person Treated	Date(s) of Treatment	Condition-Treatment and Results

5b. In the space below, please list all persons who are currently taking or have taken medication(s) within the past 5 years. (Attach additional pages as necessary and sign the additional pages.)

Person Taking Medication	Name of Medication	Dosage (mg) and Frequency <small>(i.e. one pill per day, two pills per day)</small>	Diagnosis <small>Reason for Taking</small>	Date Last Taken

I hereby apply for coverage as indicated with Agri-Services Agency (ASA). I understand that representations made herein will be used by ASA to determine final rates for my coverage. By signing below, I hereby authorize any physician, hospital, or other medical facility or professional to furnish to ASA, or its representatives, any medical record or information pertaining to me or any dependent family member in this application, even if it would otherwise be deemed confidential, on presentation of this authorization bearing my signature or a photocopy thereof.

Name of Applicant *(please print)* _____ Date: _____

Signature of Applicant _____ Contact phone number () _____