

Individual Medical Questionnaire



I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until ConnectiCare Insurance Company, Inc. ("CICI") accepts and approves both this enrollment form and the employer application.

Employer: _____ Employee ZIP code: _____

1 Complete the following information for only those individual(s) requesting coverage, and indicate if anyone is covered by Medicare.

	Last name	First name	Date of birth	Gender	Medicare Part A or B
Employee					
Spouse					
Child 1					
Child 2					
Child 3					
Child 4					

2 Indicate if you, your spouse and any of your other listed dependents have been diagnosed in the past five (5) years or currently receive treatment and/or medication for any of the following conditions.

<input type="checkbox"/> Addison's Disease	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Paraplegia
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> ALS/Lou Gehrig's Disease	<input type="checkbox"/> Diabetes - Uncontrolled	<input type="checkbox"/> Plaque Psoriasis
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Managed by prescription medication
<input type="checkbox"/> Ankylosing Spondylitis	<input type="checkbox"/> Gaucher's Disease (or other lipid storage disease)	<input type="checkbox"/> Managed by over the counter medication
<input type="checkbox"/> Autoimmune Disorder	<input type="checkbox"/> Heart Attack/Myocardial Infarction	<input type="checkbox"/> Psoriatic Arthritis
<input type="checkbox"/> Autoimmune Hepatitis	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Psychosis
<input type="checkbox"/> Bipolar Disorder (Manic Depression)	<input type="checkbox"/> Hepatitis B or C	<input type="checkbox"/> Pulmonary Fibrosis
<input type="checkbox"/> Managed by prescription medication	<input type="checkbox"/> Hereditary Angioedema	<input type="checkbox"/> Pulmonary Hypertension
<input type="checkbox"/> Inpatient stay over the past 12 months	<input type="checkbox"/> High Risk Pregnancy - History of	<input type="checkbox"/> Rheumatoid Arthritis (Juvenile/Adult)
<input type="checkbox"/> Cancer - not in remission	<input type="checkbox"/> Hypopituitarism	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Carcinoid Syndrome	<input type="checkbox"/> Inflammatory Bowel Disease	<input type="checkbox"/> Seizure Disorders
<input type="checkbox"/> Cardiac Arrhythmia	<input type="checkbox"/> Ischemic Heart Disease	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Cardiac Valve Insufficiency	<input type="checkbox"/> Leukemia (current diagnosis)	<input type="checkbox"/> Spina Bifida
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Major Depression	<input type="checkbox"/> Spinal Stenosis
<input type="checkbox"/> Castleman Disease	<input type="checkbox"/> Managed by prescription medication	<input type="checkbox"/> Stroke - History of
<input type="checkbox"/> Chronic Immune Thrombocytopenia	<input type="checkbox"/> Inpatient stay over the past 12 months	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Chronic Inflammatory Demyelinating Polyneuropathy	<input type="checkbox"/> Multifocal Motor Neuropathy	<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Chronic Renal Failure	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Thalassemia Major
<input type="checkbox"/> Chronic Wounds	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Cirrhosis of the Liver	<input type="checkbox"/> Myelodysplastic Syndrome	<input type="checkbox"/> Vasculitis
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Narcolepsy	<input type="checkbox"/> Wegner's Granulomatosis
<input type="checkbox"/> COPD	<input type="checkbox"/> Neuromyelitis Optica	
<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Pancreatitis	

Additional Notes: Using the box below, please note recommended future treatment or diagnostic testing where applicable. Be sure to include the name of any medications you take for any noted condition checked above and any treatment details.

Signature required on next page.

Certification: I hereby confirm that all answers on this form are full, complete and true to the best of my knowledge and belief. I understand that omissions, misrepresentations or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of reformation of coverage. I am duly authorized to execute this form and am employed full-time by the employer listed on the enrollment form. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, commits a fraudulent insurance act, punishable by penalties, imprisonment and restitution depending on applicable laws. I agree that my employer or its agent may send this enrollment form to CICI. I authorize all of my doctors, pharmacies, hospitals and other health care providers ("Providers") to give CICI any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV/AIDS. I further authorize CICI to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of the authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

Employee's signature	Date	Spouse's signature	Date
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Upon completion, enclose this form in an envelope, seal it, and return it to your employer.