Employee Health Questionnaire

Alternate Funded Benefit Plans with Georgia Chamber Federation and Georgia Farm Bureau Member Health Program

Administered by:

Anthem

Employee name	Height	Weight	Social Security no.	Group name
Spouse name	Height	Weight	Benefits ☐ Employee only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family	
Dependent 1	Height	Weight	Dependent 2	Height / Weight
Dependent 3	Height	Weight	Dependent 4	Height / Weight
Dependent 5	Height	Weight	Dependent 6	Height / Weight

Please answer the following questions for yourself AND any eligible dependents

Please note that no one will be denied benefits on an individual basis due to answers provided below.

1. Has anyone been treated for a serious illness, been hospitalized or had surgery in the past five years, is currently hospitalized or been advised that medical treatment, diagnostic testing, surgery, or hospitalization is necessary with the exception of AIDS/HIV? ☐ Yes ☐ No
   If "Yes", please explain below.
2. Is anyone currently being treated or been advised to seek treatment or counseling for any of the following? ☐ Yes ☐ No
   If "Yes ", please check condition(s) that apply.
   - ☐ Cancer
   - ☐ Chemical dependency
   - ☐ Blood disorders
   - ☐ Obesity
   - ☐ High blood pressure
   - ☐ Kidney disorder
   - ☐ Transplants
   - ☐ Heart disease
   - ☐ Crohn's Disease/ulcerative colitis
   - ☐ Liver disease
   - ☐ Diabetes
   - ☐ Chemical dependency/alcoholism
   - ☐ Brain tumor
   - ☐ Back/spinal disorder
   - ☐ Stroke
   - ☐ Chronic respiratory disease
   - ☐ Muscular disorder
   - ☐ Mental illness
   - ☐ Nervous system disorders
   - ☐ Currently pregnant? If, yes, due date: _____
   - ☐ Other: _____

   If "Yes", please explain below.
3. Do you or your dependents regularly take medication? ☐ Yes ☐ No
   If "Yes", please explain below.
4. In the past five years have you or any of your dependents been diagnosed with AIDS or HIV? ☐ Yes ☐ No
   If "Yes", please explain below.

Explain "Yes " answer to any question. Give complete details to avoid delay. Attach a separate sheet of paper if necessary.

Question no.	Individual name	Diagnosis	Treatment	Medication	Onset date	Treatment date(s)	Hospitalized	Surgery	Recovered
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
							☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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Employee name: _____ Social Security no. _____

I represent that all answers on this Questionnaire are true and accurate to the best of my knowledge and I understand they will be relied upon by Anthem in accepting this application. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to benefits or premium equivalent rates. Material misrepresentations or significant omissions in this application may result in increased premium equivalent rates, or benefits being denied, rescinded or cancelled.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

NOTICE OF INFORMATION PRACTICES: I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164). I also understand that under the HIPAA Privacy Regulations, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

I understand that the length of time such authorization shall remain valid shall be no longer than 30 months from the date the authorization is signed.

I agree that this executed Questionnaire will become part of the application and any contract issued on it.

Signature **X**	Date (MMDDYYYY)

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