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HEALTH INSURANCE RISK ASSESSMENT EMPLOYEE QUESTIONNAIRE

Age ____ Gender: M F Coverage (circle one): Single Employee/Spouse Employee/Child Family Waive

The following questions pertain to those family members who you will cover on your medical insurance plan:

1. Over the past three years have you or your dependents incurred more than \$2,500 in medical expenses (including prescriptions and mental/nervous/substance abuse expenses)? These include expenses which may not have been reimbursed by your insurance. Yes No
2. Are you or any of your dependents disabled and unable to perform the usual duties of your occupation? Yes No
3. Do you or your dependents have any health conditions for which surgery or hospitalization has been advised or anticipated in the immediate future? Yes No
4. Do you or your dependents have any serious health conditions (heart, high blood pressure, cholesterol, stroke, asthma, respiratory, AIDS, ARC, kidney, liver, cancer, tumors, arthritis, ulcers, colon, alcoholism, mental/nervous, substance abuse, diabetes, epilepsy, blood disorder, hemophilia, multiple sclerosis, etc.) which was not mentioned above? Yes No
5. Are you or your dependents currently pregnant? Yes No
5. Are you or your dependents currently taking physician prescribed medication (not over-the-counter medication)? Yes No

If any of the above questions have been answered "Yes", please explain below. Use the back of this questionnaire if needed.

#	Name	Date(s) of Service	Type of Illness/Injury or Medication taken (include dosage)	What, if any, remaining effects