



Tracking#: _____
(For Broker Use Only)

Health Questionnaire Form for Small Group Medical Underwriting

Instructions:

1. Please complete the health questionnaire clearly and in full or it will be returned to you resulting in a delay in processing.
2. Incomplete health questionnaires may delay the effective date of your coverage.
3. Read carefully and sign after Section D and the enclosed *Authorization for Release of Medical Information*.
4. Provide information about your spouse and dependents only if they are also applying for coverage. If you need additional space, attach a separate sheet with your signature and date.

SECTION A — Primary Applicant Information

Primary applicant name: Last, First, M.I.		Phone Number		
Street Address	County	City	State	Zip
Employer Name		Phone Number		
Employer Street Address	County	City	State	Zip

SECTION B – Family Information

If you need additional space, attach a separate sheet detailing all of the required information requested below. Please include your signature and date on any additional sheets.

Self - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				
Spouse - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				
Dependent - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				
Dependent - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				
Dependent - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				
Dependent - Name (First, MI, Last)	Social Security Number (Must be provided)	Date of Birth	Sex (M/F)	Height ____ ft ____ in	Weight
	Have you ever used tobacco products? Start/End Date: _____ If so, check the applicable boxes: Cigarettes Pipe Cigars Chewing Tobacco				



If you are providing additional sheets, check here .

Initials: _____

Benefits underwritten or administered by QCC Insurance Company or Keystone Health Plan East, subsidiaries of Independence Blue Cross — independent licensees of the Blue Cross and Blue Shield Association.

SECTION C — Health History for employees and their dependents – Incomplete answers will delay processing of your requested coverage. Please answer all questions with a Yes or No. If "Yes", please mark the appropriate condition(s) and provide complete details to all "Yes" answers in Section D — Additional Detailed Medical Information.

The following information will be used and/or disclosed by QCC Insurance Company or Keystone Health Plan East as permitted or required by the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and/or applicable state law. **In the last five years, has any applicant/dependent consulted a health care provider, been diagnosed, received treatment, or been hospitalized for any of the following conditions or diseases?**

1. Brain/Nervous System Yes No

Epilepsy (Convulsions and Seizures)
Migraines
Multiple Sclerosis
Other _____

2. Digestive System Yes No

Gallstones
Cirrhosis (Liver)
Colitis
Diverticulitis
Gastric Esophageal Reflux Disorder (GERD)
Gastric Bypass Surgery and Gastric Restrictive Surgery
Hepatitis
Ileitis (Crohn's Disease)
Other _____

3. Female Reproductive System Yes No

Current Pregnancy Due Date: _____
Is a C Section Planned?
Multiple Births Expected?
Hysterectomy
Infertility
Cervical Dysplasia
Ovarian Cyst
Other _____

4. Heart and Circulatory System Yes No

Atrial Fibrillation or Flutter
Cardiac Arrhythmia
Coronary Artery Disease
Congestive Heart Failure
Anemia
Heart attack
High cholesterol/lipids (HDL _____)
(LDL _____)
High blood pressure (Blood Pressure _____)
Phlebitis
Stroke
Other _____

5. Mental Health Conditions/Substance Abuse Yes No

Attention deficit hyperactivity disorder (ADHD)
Insomnia
Depression
Anxiety
Alcohol or Substance Abuse
Other _____

6. Metabolic and Endocrine System Yes No

Acquired Immune Deficiency Syndrome AIDS/ARC/HIV positive
Diabetes (Type I or II _____) (Blood Sugar _____)
Hypothyroidism
Thyroid Disorder
Other _____

7. Musculoskeletal System Yes No

Back Sprain or Strain
Disk, Slipped (Herniated, Ruptured)
Disk Disease, Degenerative
Fibromyalgia (Fibrositis, Myofibrositis)
Fractures
Gout
Joint Replacement (Location _____)
Knee Injury
Osteoarthritis
Osteoporosis/Osteopenia
Rheumatoid Arthritis
Rotator Cuff Syndromes
Spinal Fusion
Subluxation
Other _____

8. Respiratory System Yes No

Allergies
Asthma
Chronic Obstructive Pulmonary Disease (COPD)
Cystic Fibrosis
Sleep Apnea/Apnea of Newborn
Other _____

9. Skin Conditions Yes No

Acne
Other _____

10. Genitourinary Tract Yes No

Kidney Stones
Prostate Hypertrophy (BPH)
Renal Failure
Other _____

11. Additional Conditions/Disorders Yes No

Cancer (Type _____) (Stage _____)
Transplants
Cataracts
Other _____



Initials: _____

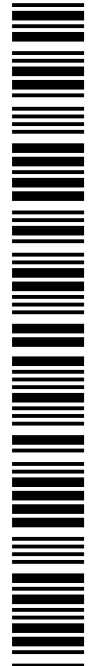
12. Has any applicant been diagnosed, treated or hospitalized for any other condition or disorder not listed in questions 1 through 11?

Yes No If "Yes," write the condition below and explain under Section D – Additional Detailed Medical Information.

SECTION D – Additional Detailed Medical Information

If you answered "Yes," to any questions in Section C, please name the appropriate condition(s) and provide complete details below. If you need additional space, attach a separate sheet detailing all of the required information requested below. Please include your signature and date on any additional sheets.

Question #	Name of Condition:	Date of Onset:
	Applicant with Condition:	
	Description of Condition/Disease:	
	Description of Current/Past Treatment:	
	Hospitalization (include purpose and dates):	
	Medications (include name of all medications currently taken for this condition, frequency & dosage):	
Question #	Name of Condition:	Date of Onset:
	Applicant with Condition:	
	Description of Condition/Disease:	
	Description of Current/Past Treatment:	
	Hospitalization (include purpose and dates):	
	Medications (include name of all medications currently taken for this condition, frequency & dosage):	
Question #	Name of Condition:	Date of Onset:
	Applicant with Condition:	
	Description of Condition/Disease:	
	Description of Current/Past Treatment:	
	Hospitalization (include purpose and dates):	
	Medications (include name of all medications currently taken for this condition, frequency & dosage):	



If you are providing additional sheets, check here .

Initials: _____

I understand that any medical condition or treatment that occurs after the signature date and before the effective date of any approved coverage will be considered in the final underwriting decision. I agree to advise the Companies of any conditions or treatments occurring during such period.

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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I acknowledge on behalf of myself, my spouse, and my minor/adult dependent children that I have read, understand all statements in this questionnaire, and have supplied the requested information. The information supplied on the questionnaire and any signed addendum is accurate and complete to the best of my knowledge. No material information has been withheld or omitted on any person applying. I understand that if my signature and date do not appear and/or my answers are incomplete, the questionnaire will either be rejected or returned for completion.

Authorization Form for Release of Medical Information

QCC Insurance Company PPO and Keystone Health Plan East Plans

I authorize QCC Insurance Company and Keystone Health Plan East (the "Companies") to obtain, use and disclose my medical claim or benefit information/data and records, and those of my spouse, my dependent children under age 18, and my adult dependent children, including but not limited to any protected health information ("PHI") contained in these records. The protected health information subject to this authorization includes medical and benefit information and/or medical records currently in the possession of the Companies relating to past, present, and future health care examinations, prescription drugs, hospitalizations, medical conditions, treatments and diagnosis, including those involving mental health (excluding psychotherapy notes, unless specifically and separately authorized), substance abuse, and HIV/AIDS. I do authorize any physician, medical practitioner, hospital, medical or medically related facility, insurer, pharmacy benefits manager, or any other health care organization to release the information as described above to the Companies. I understand the purpose of the disclosure and use of my information is to allow the Companies to make decisions regarding eligibility, enrollment underwriting, premium risk rating, and related purposes. Any PHI in the possession of the Companies or received in connection with any application may be retained by the Companies and used or disclosed in connection with future underwriting and/or renewal purposes. I understand that if I refuse to sign this authorization form ("authorization"), my refusal will impact my ability to obtain insurance.

This authorization shall remain in force for 18 months following the date of the signature(s) below. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notice to Independence Blue Cross, Medical Underwriting Department, 1901 Market Street, Philadelphia, PA 19103-1480. I understand that a revocation is not effective to the extent the Companies or any other person have already relied on this authorization to use, disclose or collect information, or to the extent the Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that the PHI disclosed based on this authorization may be subject to re-disclosure and may then be no longer protected by the federal privacy rule. However, the Companies are required to comply with the HIPAA Privacy Rule and any re-disclosure of information by the Companies will be done consistent with the HIPAA Privacy Rule.

I have had full opportunity to read and consider the contents of this authorization, discussed the content of this authorization with my spouse and adult dependent children, and received their permission, consent, and authorization to sign this authorization on their behalf. I understand that, by signing this authorization, I am confirming on behalf of myself, my spouse, and my adult dependent children the authorization of the use and/or disclosure of our PHI, as described in this form.



Signature of proposed primary insured

____/____/____
Date

Initials: _____