WESTERN MUTUAL INSURANCE® COMPANY

P.O. Box 572450 ♦ Salt Lake City, Utah ♦ 84157-2450
(801) 263-8000 ♦ (800) 748-5340 ♦ Fax: (801) 263-1247

EMPLOYEE GROUP HEALTH QUESTIONNAIRE

EMPLOYEE INFORMATION (Please print using ink)

Employee Name ____________________ Employer ____________________
Employee Address ____________________
Street City State Zip
Full-Time Hire Date __________ Job Title __________ Hours Worked Each Week ______
Home Phone __________ Work Phone __________ Cell Phone __________
Social Security # __________ Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Date of Birth __________ Sex: M ☐ F ☐ Height:______ ft. ______ in. Weight: ______
Personal E-mail ____________________ (official use only)
Medical Coverage Requested:

☐ Employee Only ☐ Employee and Spouse ☐ Employee and Child ☐ Employee and Children ☐ Family

DEPENDENT INFORMATION

Full Name* (First, Middle Initial, Last)	**Relationship to Employee**	**Social Security #** (For Internal Use Only)	**Sex** M/F	**Birth Date**	**Height & Weight**	**Other Medical Insurance**	**Name of Other Medical Insurer**
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	
					___ft. __in. wt.____	☐ Yes ☐ No	

* To be eligible for coverage, children must be the dependent age provided by statute, unmarried, and dependent upon you for 50% of their support. ANY DEPENDENT NOT LISTED WILL NOT BE CONSIDERED FOR COVERAGE.

PREEXISTING CONDITION EXCLUSION AND PORTABILITY CREDITS: If you have been issued a certificate of creditable coverage within the last 63 days, your Preexisting Condition waiting period limitation may be credited or waived upon receipt of your Certificate of Creditable Coverage from your prior health care plan. Benefits may not be payable for Preexisting Conditions for a period of twelve (12) months (six months in New Mexico) following your effective date of coverage (eighteen (18) months for a late enrollee). A Preexisting Condition is an illness or injury for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period prior to the enrollment date of coverage. **If a preexisting provision applies, each participant has the right to prove prior creditable coverage, including the right to secure a certificate from a prior plan of coverage.** WMI will assist you in obtaining the certificate from your prior plan, if necessary.

To obtain additional information regarding the preexisting condition exclusion, please contact the WMI Claims Department at (801) 263-8000 or (800) 748-5340. If you have been issued a certificate of creditable coverage within the last sixty-three (63) days, **please enclose a copy of the Certificate of Creditable Coverage for each member to be covered** as proof of any prior coverage dating up to eighteen (18) months prior to the date of completion of this questionnaire and provide the following information:

Policyholder's Name ____________________ Name of Prior Insurance Carrier or Plan ____________

Policy No. ____________ Date Coverage Began ________ Date Coverage Ended __________

Submission of prior coverage information does not automatically waive the Preexisting Condition Waiting Period limitation. However, failure to provide prior coverage information will result in limited or excluded benefits for a 12-month period (18 months for late enrollees).

HEALTH INFORMATION - STATEMENT OF PHYSICAL CONDITION

Instructions:

1. Each medical question below applies to all individuals listed on this questionnaire who desire coverage.
2. The questions apply to both past and present symptoms, conditions, diseases, illnesses, accidental injuries, and deformities (health conditions). Each of the questions **must** be answered either Yes or No. **Do not leave any questions unmarked**.
3. Answer each question accurately and explain any "yes" answers in the boxes provided. **Circle** any specific item(s) in the question that applies. **If necessary, use additional sheets of paper.**

1. Within the past 12 months has (or is) anyone: Yes No

a. Pregnant or financially responsible for an unborn child or anticipating adoption or applying for adoption? If Yes, due date: ______________________________ ☐ ☐
b. Miscarried, c-section, or complications of pregnancy? ☐ ☐
c. Used any medication or prescription drugs? ☐ ☐
d. Currently under medical care or treatment? ☐ ☐

2. Within the past 5 YEARS has anyone been diagnosed or treated for any of the following: Yes No

a. Been **advised** to be hospitalized, have tests, consultation, evaluation, surgery, or use medication(s) **and not done so**? ☐ ☐
b. Disorder of the female reproductive organs or infertility? ☐ ☐
c. Disorder of the male reproductive organs, prostate or infertility? ☐ ☐
d. Allergies, hay fever, sinus condition or adverse drug reactions? ☐ ☐
e. Eye, ear, nose, or throat condition? ☐ ☐
f. Varicose veins or any circulatory disorder? ☐ ☐
g. Chest pain, irregular heart beat, or any other cardiovascular condition? ☐ ☐
h. Bladder, urinary disorder, incontinence, or any other gallbladder disorder? ☐ ☐
i. Back, neck, spine, foot, knee, sprain, strain, jaw disorder, bone disorder, joint condition, fracture or dislocation? ☐ ☐
j. Anemia, hemophilia, blood or bleeding disorder? ☐ ☐
k. Thyroid, goiter, pituitary or any other lymph system disorder? ☐ ☐
l. Breast lumps, augmentation, reduction, or fibrocystic breast disease? ☐ ☐
m. Ulcers, hernias, chronic diarrhea, diverticulosis, GERD, reflux, or digestive disorder? ☐ ☐
n. Psoriasis, abnormal moles, growths (except warts), or any other skin disorder? ☐ ☐
o. Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys or pancreas? ☐ ☐
p. Headaches, migraines, epilepsy, seizures or convulsions? ☐ ☐
q. Polyp(s), hemorrhoids, or any other rectal disorder? ☐ ☐
r. Depression, anxiety, mental disorder, hyperactivity, ADD or ADHD, chemical imbalance, or nervous condition that received any counseling, psychotherapy, or medication? ☐ ☐
s. Tobacco Use (Chewing or Smoking)? ☐ ☐

3. Within the past 10 YEARS has anyone been diagnosed or treated for any of the following: Yes No

a. Hospitalization or surgery? ☐ ☐
b. Asthma, pleurisy, tuberculosis, sleep apnea, emphysema or any other disorder of the lungs or respiratory system? ☐ ☐
c. Lupus, gout, fibromyalgia, Crohn's disease or colitis? ☐ ☐
d. Alcohol use/abuse, been advised to reduce/limit use or attend alcohol counseling (or similar program) drug use/abuse, dependency or misuse of prescribed or non-prescribed drugs or convicted of DUI or DWI? ☐ ☐
e. Obesity, bulimia, anorexia, weight control, gastric bypass or stomach stapling? ☐ ☐
f. Osteopenia, osteoporosis, neuropathy, spina bifida, kyphosis, scoliosis, spinal or herniated and/or ruptured disc? ☐ ☐

4. Has anyone EVER been diagnosed or treated for any of the following: Yes No

a. Cancer (including skin cancer), tumors or cyst(s)? If yes, list type and stage ______________________________ ☐ ☐
b. Heart murmur, heart attack, bypass surgery, blood clot, stroke, heart surgery, or coronary artery disease? ☐ ☐
c. High blood pressure? If yes, last reading and date: ______________________________ ☐ ☐
d. High cholesterol? If yes, last reading and date: ______________________________ ☐ ☐
e. Liver conditions, cirrhosis or hepatitis? If yes, list type: ______________________________ ☐ ☐
f. Arthritis, rheumatism or joint replacement? If yes, list type: ______________________________ ☐ ☐
g. Multiple sclerosis, muscular dystrophy, Parkinson's, Lou Gehrig's disease (ALS) Alzheimer's disease or dementia? ☐ ☐
h. Diabetes? Type I ☐ or Type II ☐ ☐ ☐
i. Positive test for HIV, treated for or diagnosed with AIDS, AIDS Related Complex (ARC) or disorder of the immune system? ☐ ☐
j. Bipolar disorder, manic depression, schizophrenia, chronic organic brain syndrome, psychotic disorder or attempted suicide? ☐ ☐
k. Paralysis? ☐ ☐
l. Bodily deformity, development or learning disability, mental impairment, down syndrome, autism or congenital disease/defect, premature birth? ☐ ☐

5. Is anyone unable to work or perform routine daily functions for longer than two weeks? (other than pregnancy) ☐ ☐

6. Has anyone been denied or turned down for other health or life insurance or been given a modified or rated policy? ☐ ☐

7. Does anyone have a condition not indicated above for which medical treatment, counseling or care has been recommended or received in the past, or is expected to be received by any person applying for coverage? ☐ ☐

ANSWERS TO QUESTIONS - Must be completed for any "YES" answer above, (**continued on the next page**):

Question # and Letter	Name of Individual	Diagnosis of Illness or Injury, Treatment, Testing or Medical Attention	Date Began	Date Ended	Remaining Symptoms or Problems	Name of Doctor or Hospital

ANSWERS TO QUESTIONS CONT. - Must be completed for any "YES" answer above (**use additional sheets as necessary**):

Question # and Letter	Name of Individual	Diagnosis of Illness or Injury, Treatment, Testing or Medical Attention	Date Began	Date Ended	Remaining Symptoms or Problems	Name of Doctor or Hospital

PRESCRIPTION DRUGS- Must be completed for any medications prescribed in past 12 months (**use additional sheets as necessary**):

Name of Individual	Name of Medication	Dosage	Date Began	Date Ended	Reason for Medication	Name of Prescribing Doctor

LIST ANY DEPENDENTS WHO ARE NOT APPLYING FOR COVERAGE (**use additional sheets as necessary**):

Name of Individual	Relationship to Employee	Sex	Birth Date	Current Health Status

GENERAL INFORMATION

Will any portion of the premium be paid by or on behalf of the employer, either directly or through wage adjustments or other means of reimbursement? Yes ____ No ____

Will any insured individual treat the health benefit plan as part of a plan or program for the purposes of sections 106, 125 or 162 of the Internal Revenue Code? Yes ___ No ____ If yes, is any part of the plan or program funded by the employer? Yes ___ No ___

To help you answer the above question, the following information is provided:

1) Section 106 is in regard to an Archer MSA, FSA or HSA.
2) Section 125 is in regard to a Cafeteria Plan.
3) Section 162 is in regard to a tax deduction being allowed for expenses incurred in carrying on a trade or business.

AUTHORIZATION

I hereby apply to be enrolled with my listed dependents, if applicable, for coverage with Western Mutual Insurance Company ("WMI"). I understand no coverage will be in force until each person listed above is approved by WMI, that no benefits will be provided for any service which begins before the coverage is effective, and that benefits will not extend beyond the termination of my coverage. I understand that omissions or misrepresentations regarding information provided on this questionnaire could cause an otherwise covered service to be denied and/or void any coverage issued.

I authorize any physician, medical practitioner, hospital, clinic, any other provider of health care, or insurance company to disclose to WMI or its representatives all information and records of myself and my dependents relating to diagnosis, treatment, medical history, physical or mental condition, and evaluation thereof for which coverage by WMI is sought. I expressly waive on behalf of myself, my spouse and such dependents any legal action for such disclosure. This authorization shall remain valid for a period not to exceed twenty-four (24) months. A copy of this authorization shall have the same effect as the original.

I hereby declare that to the best of my knowledge and belief, the information given on this questionnaire, including the health information listed on the Statement of Physical Condition, is correctly recorded, true and complete. If I subsequently become aware of information different from that provided in this questionnaire, I agree to provide that information promptly to WMI. I understand that WMI retains the right to retroactively adjust premium rates and/or rescind coverage if necessary due to any incorrect information that is provided on this questionnaire.

EMPLOYEE SIGNATURE ____ **DATE** ______________________

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or who knowingly presents false information during the application process is guilty of a crime and may be subject to civil fines and criminal penalties.