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 had health insurance 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.**

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 had health 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 |
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**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 |
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**PRESCRIPTION DRUGS**- Must be completed for any medications prescribed in past12 months (**use additional sheets as necessary**):

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

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**ENROLLMENT FORM - Print clearly in ink.**

Name of Employee ______________________________
Last First Initial Social Security # Birth Date Home Phone

Mailing Address ______________________________
City State Zip Business Phone Date of Hire Hours Worked Weekly

Employer ______________________ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse: ______________________________
Last First Initial Birth Date Social Security #

| Names of Dependent Children | Sex | Birth Date | Social Security # |
|---|---|---|---|
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Type of Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Children ☐ Family

Medical:______________________ Dental: * ☐ Yes ☐ No Vision:* ☐ Yes ☐ No Disability:* ☐ Yes ☐ No

**Group Life Insurance**: *☐ Smoker ☐ Non-Smoker Amount: ☐$10,000 ☐$25,000 ☐$50,000 ☐$75,000 ☐$100,000 ☐Other ______________

**Spouse:** ☐ Smoker ☐ Non-Smoker Amount: ☐$10,000 ☐$25,000 ☐$50,000 ☐$75,000 ☐$100,000 ☐Other ______________

* Dental, Vision, Disability and Life insurance are subject to employer election and approval. Life insurance amounts in excess of $25,000 require pre-approval.

Dependent Life: ☐ None ☐ One $3,000 Unit ☐ Two $3,000 Units ($6,000 total)

Beneficiary: ______________________________
Name Relationship Contingent

Spouse's:
Beneficiary: ______________________________
Name Relationship Contingent

______________________ ______________
**EMPLOYEE SIGNATURE** **DATE**

**For Office Use Only**
Effective Date: ____________ Termination Date: __________
Class Change Date: _________ VGL Amount: _____________
Disability Income Amount: ______________________
☐ Original Group ☐ Special Enrollee
☐ New Employee ☐ Late Enrollee

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

WMI EE APP (11/07) ------------------------------------------------------------------------------------------------------------------------------------------------------------

## WAIVER OF GROUP COVERAGE

**(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY ANY ELIGIBLE EMPLOYEE)**

EMPLOYEE NAME ____________________ SOCIAL SECURITY #_______________ EMPLOYER NAME ___________________

☐ I WAIVE ALL COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)

☐ I WAIVE HEALTH PLAN COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)

☐ I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY

☐ I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):
☐ COVERED BY SPOUSE'S COVERAGE
☐ COVERED BY OTHER INSURANCE OR HMO
☐ COVERED BY CHAMPUS OR CHAMPVA
☐ OTHER (EXPLAIN) ______________________

**THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.**

**If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department at (801) 263-8000 or (800) 748-5340.**

______________________________ ______________________
**EMPLOYEE SIGNATURE** **DATE**