

Regence BlueCross BlueShield of Utah, Regence ValueCare and Regence HealthWise are Independent Licensees of the Blue Cross and Blue Shield Association

## GROUP HEALTH QUESTIONNAIRE

**MUST BE COMPLETED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS INCLUDING ALL WHO ARE WAIVING COVERAGE  
AN INCOMPLETE QUESTIONNAIRE WILL BE RETURNED**

Name of Employer's Group \_\_\_\_\_

Employee's Name \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Social Security No. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Dependent Children's Names \_\_\_\_\_

Complete the following information for all family members (whether or not they are applying for coverage). Consult with them to ensure that the information you provide is true, accurate and complete. **You cannot be denied coverage on the basis of any health history that you provide which is true, accurate and complete to the best of your knowledge.**

<p>1. Have you or any listed family members EVER experienced problems or been diagnosed with or been treated for any of the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;"><b>Yes</b></td> <td style="text-align: center;"><b>No</b></td> </tr> <tr> <td>a. tumor? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. cancer or leukemia? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. heart, blood or blood vessels? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. lupus, multiple sclerosis, arthritis or gout? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. diabetes? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. liver, gallbladder or thyroid? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. lungs? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. dizziness, blackout, convulsions, loss of consciousness or epilepsy? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>i. back pain or other back problems? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>j. sexually transmitted disease? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>k. congenital or physical disorder? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>l. brain or nervous system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>m. stroke? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>n. lymph system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>o. immune system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>p. colitis? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>q. ulcer? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>r. sleep disorders? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		<b>Yes</b>	<b>No</b>	a. tumor? .....	<input type="checkbox"/>	<input type="checkbox"/>	b. cancer or leukemia? .....	<input type="checkbox"/>	<input type="checkbox"/>	c. heart, blood or blood vessels? .....	<input type="checkbox"/>	<input type="checkbox"/>	d. lupus, multiple sclerosis, arthritis or gout? .....	<input type="checkbox"/>	<input type="checkbox"/>	e. diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>	f. liver, gallbladder or thyroid? .....	<input type="checkbox"/>	<input type="checkbox"/>	g. lungs? .....	<input type="checkbox"/>	<input type="checkbox"/>	h. dizziness, blackout, convulsions, loss of consciousness or epilepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>	i. back pain or other back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>	j. sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>	k. congenital or physical disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	l. brain or nervous system? .....	<input type="checkbox"/>	<input type="checkbox"/>	m. stroke? .....	<input type="checkbox"/>	<input type="checkbox"/>	n. lymph system? .....	<input type="checkbox"/>	<input type="checkbox"/>	o. immune system? .....	<input type="checkbox"/>	<input type="checkbox"/>	p. colitis? .....	<input type="checkbox"/>	<input type="checkbox"/>	q. ulcer? .....	<input type="checkbox"/>	<input type="checkbox"/>	r. sleep disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>	<p>2. Within the LAST FIVE YEARS, have you or any listed family members experienced problems or been diagnosed with or been treated for any of the following:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td></td> <td style="text-align: center;"><b>Yes</b></td> <td style="text-align: center;"><b>No</b></td> </tr> <tr> <td>a. high blood pressure? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. bones, joints or muscular system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. intestines, stomach or pancreas? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. male or female organs (including but not limited to prostate gland or breast(s))? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. mental illness, emotional disorder, anxiety, depression, chemical imbalance or an eating disorder? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. alcohol or drug dependency or illegal drug use? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. kidney or urinary system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. severe headache? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>i. glands or hormone system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>j. anemia? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>k. asthma? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>l. infertility? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> <p>3. Have you or any dependent ever been told that treatment may be required in the future? <b>Yes No</b></p> <p style="text-align: right;">..... <input type="checkbox"/> <input type="checkbox"/></p>		<b>Yes</b>	<b>No</b>	a. high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>	b. bones, joints or muscular system? .....	<input type="checkbox"/>	<input type="checkbox"/>	c. intestines, stomach or pancreas? .....	<input type="checkbox"/>	<input type="checkbox"/>	d. male or female organs (including but not limited to prostate gland or breast(s))? .....	<input type="checkbox"/>	<input type="checkbox"/>	e. mental illness, emotional disorder, anxiety, depression, chemical imbalance or an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	f. alcohol or drug dependency or illegal drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>	g. kidney or urinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>	h. severe headache? .....	<input type="checkbox"/>	<input type="checkbox"/>	i. glands or hormone system? .....	<input type="checkbox"/>	<input type="checkbox"/>	j. anemia? .....	<input type="checkbox"/>	<input type="checkbox"/>	k. asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>	l. infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>	<p>4. Are you or any dependent currently using any prescription medications? <b>(please list specific prescriptions below)</b> <b>Yes No</b></p> <p>..... <input type="checkbox"/> <input type="checkbox"/></p> <p>5. Do you or any dependent have or suspect any conditions, symptoms or problems (physical or mental) not otherwise mentioned? <b>Yes No</b></p> <p>..... <input type="checkbox"/> <input type="checkbox"/></p> <p>6. Are you or any family member <b>(either applying for or waiving coverage)</b> currently pregnant? <b>Yes No</b></p> <p>..... <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, what is the expected date of delivery? ___/___/___</p> <p>If yes, are difficulties, problems or complications anticipated with the pregnancy, delivery or newborn child? <b>Yes No</b></p> <p>..... <input type="checkbox"/> <input type="checkbox"/></p> <p>7. Have any difficulties, problems or complications been experienced with prior pregnancies, deliveries or newborn children? <b>Yes No</b></p> <p>..... <input type="checkbox"/> <input type="checkbox"/></p>
	<b>Yes</b>	<b>No</b>																																																																																																
a. tumor? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
b. cancer or leukemia? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
c. heart, blood or blood vessels? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
d. lupus, multiple sclerosis, arthritis or gout? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
e. diabetes? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
f. liver, gallbladder or thyroid? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
g. lungs? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
h. dizziness, blackout, convulsions, loss of consciousness or epilepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
i. back pain or other back problems? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
j. sexually transmitted disease? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
k. congenital or physical disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
l. brain or nervous system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
m. stroke? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
n. lymph system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
o. immune system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
p. colitis? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
q. ulcer? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
r. sleep disorders? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
	<b>Yes</b>	<b>No</b>																																																																																																
a. high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
b. bones, joints or muscular system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
c. intestines, stomach or pancreas? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
d. male or female organs (including but not limited to prostate gland or breast(s))? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
e. mental illness, emotional disorder, anxiety, depression, chemical imbalance or an eating disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
f. alcohol or drug dependency or illegal drug use? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
g. kidney or urinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
h. severe headache? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
i. glands or hormone system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
j. anemia? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
k. asthma? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																
l. infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>																																																																																																

**8. FOR EACH QUESTION 1 THROUGH 7 ABOVE ANSWERED "YES," PLEASE COMPLETE THE FOLLOWING: (more space provided on back)**

Item # & Letter	Patient's First Name	List condition, disorder, disease, problem, treatment, medication and degree of recovery	Was Patient Hospitalized?		Dates of Care		Actual or Expected Cost of Care
			Yes	No	First	Last	
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>			

I certify that I have consulted all family members (whether applying for or waiving coverage) about their health history and that the above information is true, accurate and complete to the best of my knowledge. I acknowledge that any coverage issued by Regence BlueCross BlueShield of Utah, Regence ValueCare and/or Regence HealthWise (hereinafter referred to as "the Plan") will be issued in reliance upon the truth, accuracy and completeness of this information, **but understand that coverage cannot be denied on the basis of any health history that I provide which is, to the best of my knowledge, true, accurate and complete.** Should any information provided by me in this questionnaire not be true, accurate and complete to the best of my knowledge, the Plan shall have the right to declare my contract null and void in accordance with applicable provisions of Utah state law.

I hereby authorize any health-care professional or other person or entity to release to the Plan any record, document or other information in connection with any inquiry or investigation into the truth, accuracy or completeness of the information I have provided herein. I further agree to execute releases requested by the Plan for medical and other records and agree that the Plan may cancel my coverage retroactive to its original effective date if I refuse to provide such a release within thirty (30) days after request by the Plan.

I understand and agree that this and all other documents submitted by me remain the exclusive property of the Plan.  
alforms4lgrp h-quest.qxd

Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to attorney fees, expenses of discovery, witness fees, stenographer, translators and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both myself and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

**I have the option of returning this form to my employer, or I may mail it directly to Regence BlueCross BlueShield of Utah, Membership Department, P.O. Box 30270, Salt Lake City, UT 84130-0270.**

Employee's Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

