BlueCross BlueShield of Florida Health Options®

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INDIVIDUAL MEDICAL QUESTIONNAIRE

Eligible Employee Data:

Name (last, first, middle initial)		Birthdate	SS Number	Weight	Height		Tobacco Usage	
				lbs	Ft.	In.	Yes [ ]	No [ ]
Name (last, first, middle initial)	**Relation**	**Birthdate**	**SS Number**	**Weight**	**Height**		**Tobacco Usage**	
				lbs	Ft.	In.	Yes [ ]	No [ ]
				lbs	Ft.	In.	Yes [ ]	No [ ]
				lbs	Ft.	In.	Yes [ ]	No [ ]
				lbs	Ft.	In.	Yes [ ]	No [ ]
				lbs	Ft.	In.	Yes [ ]	No [ ]

All of the following questions must be answered with respect to each person for whom you are applying for coverage. Has anyone listed on this application ever had medical advice, treatment or have reasons to know of health problems with regard to the following? Check Yes or No. THIS INFORMATION WILL BE USED TO EVALUATE MEDICAL RISK, NOT ELIGIBILITY FOR COVERAGE

Yes [ ] No [ ] 1. Is any person listed on this application receiving medical treatment, taking medication or currently hospitalized?

Yes [ ] No [ ] 2. Is any person listed on this application pregnant?

Yes [ ] No [ ] 3. Has any person listed on this application been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?

Yes [ ] No [ ] 4. In the past year has any person listed on this application been diagnosed with or received treatment for any of the following (Check all that apply)?

Bladder Disorder	Yes [ ]	No [ ]	High Blood Pressure	Yes [ ]	No [ ]	Prostate Disorder	Yes [ ]	No [ ]
Blood disorder	Yes [ ]	No [ ]	Joint Disorder	Yes [ ]	No [ ]	Respiratory disorder	Yes [ ]	No [ ]
Bone Disorder	Yes [ ]	No [ ]	Kidney Disorder	Yes [ ]	No [ ]	Rheumatoid Arthritis	Yes [ ]	No [ ]
Cancer	Yes [ ]	No [ ]	Liver Disorder	Yes [ ]	No [ ]	Seizures	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]	Mental Disorder	Yes [ ]	No [ ]	Stroke	Yes [ ]	No [ ]
Ear/Eye/Nose/Throat	Yes [ ]	No [ ]	Multiple Sclerosis	Yes [ ]	No [ ]	Tuberculosis	Yes [ ]	No [ ]
Heart Condition	Yes [ ]	No [ ]	Neurological Disorder	Yes [ ]	No [ ]	Tumors	Yes [ ]	No [ ]
Hepatitis C	Yes [ ]	No [ ]	Muscle Disorder	Yes [ ]	No [ ]	Urinary Disorder	Yes [ ]	No [ ]

If you answered "Yes" to any of the medical questions, please complete the following: Use a separate page if additional space needed.

Name	Date Diagnosed/Treated	Duration of Illness
Diagnosis	Treatment Received	
List All Medications		
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Diagnosis	Treatment Received	
List All Medications		
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Diagnosis	Treatment Received	
List All Medications		
Name	Date Diagnosed/Treated	Duration of Illness
Diagnosis	Treatment Received	
List All Medications		

I have read this application carefully and I represent that the information included is true and complete to the best of my knowledge and belief. No information has been withheld or omitted concerning the past and present state of health of myself and any family member applying for this coverage. I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee's Signature		Date Signed