BlueCross BlueShield of Florida
Health Options®

Health Options and its Parent, Blue Cross and Blue Shield of Florida, are Independent Licensees of the Blue Cross and Blue Shield Association.

GROUP MEDICAL QUESTIONNAIRE

4 - 50 GROUP SIZE

GENERAL INFORMATION

GROUP NAME: _____

GROUP ADDRESS: _____

_____

EFFECTIVE DATE: _____

MEDICAL HISTORY

Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children).

Within the past 24 months, has any employee or dependent had a continuing claim (i.e. chronic or ongoing) due to any of the conditions below? Please check the appropriate box(es).

☐ ARC or AIDS	☐ Cardiovascular	☐ Infertility	☐ Neurological
☐ Alcohol Abuse	☐ Diabetes	☐ Intestines	☐ Pancreas
☐ Arthritis	☐ Drug/Substance Abuse	☐ Kidney	☐ Skin
☐ Back, Neck	☐ Epilepsy	☐ Liver	☐ Stomach
☐ Blood	☐ Ears/Eyes	☐ Lungs	☐ Stroke/Paralysis
☐ Bone/Joint	☐ Emphysema/Pulmonary	☐ Lupus	☐ Venereal
☐ Brain	☐ Heart Disease	☐ Mental/Nervous	☐ Other, Detail Below
☐ Cancer/Tumor	☐ High Risk Pregnancies	☐ Migraines	

If you have checked any of the above conditions, using your best existing knowledge please complete the following for each affected employee/dependent.

CONDITION	MEDICATION	YEARS OF TREATMENT

This information will be used to determine the medical risk associated with this group. The undersigned Authorized Company Officer hereby acknowledges that the information on this form is complete and true to the best of his or her knowledge. The undersigned Authorized Company Officer and Agent further represents that the summary health information provided above was not acquired, used, or disclosed other than as is permitted by applicable law, and specifically was not and will not be used for employment-related actions and/or decisions. 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.

Authorized Company Officer:

Name/Title (Print): _____

Signature: _____ **Date:** _____

Agent Name/Number/Agency (Print) _____

Agent Signature: _____ **Date:** _____