PARTNERS HEALTH ALLIANCE
PO BOX 146 | MCCOOK, NE 69001
Phone: 1.844.PHA.WORKS
Fax: 1.308.345.1975

MEDICAL DISCLOSURE QUESTIONNAIRE

The information in this form is extremely important to adequately underwrite your employers Medical Stop Loss Coverage. We are committed to protecting your privacy and the medical information you provide is used solely for the underwriting of the groups reinsurance coverage.

General Information. Please review for accuracy and finish completing.

Employer Name:		Employee Location:	
Employee Name:		Waiver of Healthcare Coverage:	☐ Yes ☐ No
Employee Address, City, State, Zip Code:			
Employment Status:	☐ Active ☐ Disabled ☐ Cobra	Cobra start date:	Cobra end date:
Date of Hire:		Phone Number:	

Employee and Dependent Information

Complete for Employee and all individuals to be covered:

Name	Social Security Number	DOB	Sex	Height	Weight	Tobacco Use	Disabled	Other Insurance
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
			☐F ☐M			☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Other Insurance or Medicare

If you indicated that you and/or your dependent(s) will have other insurance coverage when this policy begins, please complete the following:

Other Insurance Company:		Name of Policy Holder:	
Medicare: ☐ Yes ☐ No	Medicare Part A Effective Date:	Medicare Part B Effective Date:	
Qualification for Medicare:	☐ Age ☐ Disability ☐ ESRD ☐ Lou Gehrig's Disease		

Medical Information

Has any applicant been diagnosed with, treated for, or had any medical advice, or have symptoms that may indicate any of the following?:

1. Cancer, leukemia, multiple myeloma or tumor(s)? ☐Yes ☐No	2. Hemophilia or other blood clotting disorder? ☐Yes ☐No
3. Heart attack, heart surgery, congestive heart failure, heart valve disorder or other heart/vascular disorder? ☐Yes ☐No	4. Aplastic anemia, Sickle Cell Anemia, other anemia, agranulocytosis, thrombocytopenia or other blood disorder? ☐Yes ☐No
5. Stroke, transient ischemic attack (mini-stroke), aneurysm or other cerebrovascular disorder? ☐Yes ☐No	6. Parkinson's Disease, Cerebral Palsy, epilepsy, migraines or other brain disorder? ☐Yes ☐No
7. Emphysema, COPD, Cystic Fibrosis, asthma, other respiratory disorder? ☐Yes ☐No	8. Hepatitis, cirrhosis or other liver disorder? ☐Yes ☐No
9. Multiple Sclerosis, Guillain-Barre, or other nervous system disorder? ☐Yes ☐No	10. HIV/AIDS or other immune suppressed disorder? ☐Yes ☐No
11. Lupus, Scleroderma or other auto-immune disorder? ☐Yes ☐No	12. Disorder of pancreas or gallbladder? ☐Yes ☐No
13. Diabetes type I or II? ☐Yes ☐No	14. Skin disorder (psoriasis, eczema, acne, other)? ☐Yes ☐No
15. Disorder of kidney (failure or dialysis), or genitourinary system? ☐Yes ☐No	16. Congenital disorder or other birth defect? ☐Yes ☐No
17. GERD (acid reflux), stomach ulcers or other disorder of the esophagus? ☐Yes ☐No	18. Mental/emotional disorder, alcohol/substance abuse? ☐Yes ☐No
19. Arthritis (osteo, rheumatoid, other), disorder of bones, joint, muscles tendon or cartilage? ☐Yes ☐No	20. Disorders of the spine, scoliosis, kyphosis, disc herniation, neck or back pain? ☐Yes ☐No
21. Currently pregnant with a high risk pregnancy or birth defects, previous history of premature delivery, multiple gestation? Due date ? ☐Yes ☐No	22. Crohn's Disease, ulcerative colitis, diverticulitis, IBS or other disorder of the intestines? ☐Yes ☐No
23. Disorder of thyroid, pituitary, adrenal, other glands or requiring growth hormone? ☐Yes ☐No	24. Any stem cell or organ transplant (planned, recommended or already performed? ☐Yes ☐No
25. Any other medical conditions or injury not mentioned elsewhere on this form for which hospitalization has occurred or other treatment has been received in the last 2 years or is anticipated in the next 12 months? ☐Yes ☐No	26. Any medical conditions/illness resulting in medical expenses more than $5000 in the past 12 months? ☐Yes ☐No

Details

Complete the following for any "Yes" answers above - Attach additional pages if necessary

Question #	Individual's Name	Diagnosis and date of onset	Treatment and/or Medications	Provider, City, State	Ongoing?
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No
					☐Yes ☐No

I certify that the information contained in this medical disclosure questionnaire form is true and correct to the best of my knowledge. I understand intentional misstatements on this form may constitute insurance fraud and result in potential persecution and/or recession of coverage.

Signature of Applicant: _____ **Date:** _____