

# MEDICAL QUESTIONNAIRE

Please complete and sign where applicable.



## Important – Please Print

This form cannot be considered current unless we receive it within 30 days of completion. The information will be considered current for no longer than 90 days after completion. All questions must be answered completely by the employee, and the form must be dated and signed. When the form has been completed, please return it to your employer.

After we receive the completed form, it will be sent for evaluation by underwriting. No insurance will go into effect until you have been notified of your group's acceptance by CIGNA Healthcare of North Carolina, Inc..

### GENERAL INFORMATION

Employee Name		Social Security Number	Date of Birth
Employee Address	Street	City	State
			Zip Code
Employer Name			

### WAIVER

I waive health coverage because:

- Have other group health coverage
  Other reason(s), explain \_\_\_\_\_  
 For  Myself (no eligible dependents)
  Myself and my dependents
  My dependents

I have declined coverage of my own free will without inducement or pressure by my employer, the agent or health insurer. I understand that if I and/or my dependents waive coverage and desire to participate in the plan at a later date, we will be subject to medical underwriting as a late enrollee.

If you have waived coverage please sign here \_\_\_\_\_ Date \_\_\_\_\_

If you have waived coverage do not complete the rest of this form.

### MEDICAL HISTORY

Indicate below if you or any of the proposed insureds currently has, or has ever had any of the listed symptoms/diseases (treated or not)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	1. High blood pressure, pain or pressure in chest, shortness of breath, irregular heart beats, heart murmur or other disease of the heart?	<input type="checkbox"/>	<input type="checkbox"/>	11. Confinement in a hospital, sanitarium or other medical facility for treatment, observation or diagnosis?
<input type="checkbox"/>	<input type="checkbox"/>	2. Stroke, paralysis, epilepsy, chronic or severe headaches or any disease of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	12. Disorders of the immune system, including disorders of gammaglobulin synthesis (hypogammaglobulinemia), white blood cell production or maturation, immunodeficiency disorders (both congenital and acquired), Human Immunodeficiency Virus (HIV) positivity, or Acquired Immune Deficiency Syndrome (AIDS) or (AIDS) Related Complex?
<input type="checkbox"/>	<input type="checkbox"/>	3. Pleurisy, asthma, allergies, tuberculosis, spitting of blood; chronic cough or any disease of the throat or lungs?	<input type="checkbox"/>	<input type="checkbox"/>	13. Been counseled, consulted or treated for alcoholism or drug habit?
<input type="checkbox"/>	<input type="checkbox"/>	4. Chronic indigestion, gastric or duodean ulcer, diabetes, jaundice, chronic diarrhea, gall stones or any disease of the liver?	<input type="checkbox"/>	<input type="checkbox"/>	14. Are you currently using a controlled or prohibited substance?
<input type="checkbox"/>	<input type="checkbox"/>	5. Kidney stones or any disease of the kidneys or bladder?	<input type="checkbox"/>	<input type="checkbox"/>	15. Mental, emotional, adjustment reactions or other nervous disorder?
<input type="checkbox"/>	<input type="checkbox"/>	6. Enlarged glands, goiter, cancer or any tumor, gout, arthritis or rheumatism; any disease or disorder of the skin, bones or joints; any defect of hearing or eyesight?	<input type="checkbox"/>	<input type="checkbox"/>	16. Psychiatric advice, examination, consultation or treatment during past 5 years not mentioned above.
<input type="checkbox"/>	<input type="checkbox"/>	7. Disease or disorder of the female/male reproductive organs; breast disease or disorder, uterine menstrual disorder or prostate disorder?	<input type="checkbox"/>	<input type="checkbox"/>	17. Unexplained weight loss/gain during the past year?
<input type="checkbox"/>	<input type="checkbox"/>	8. A current pregnancy? (indicate expected due date _____)	<input type="checkbox"/>	<input type="checkbox"/>	18. Does any member of your family smoke? (list who and how many packs per day on reverse of this sheet)
<input type="checkbox"/>	<input type="checkbox"/>	9. Organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	19. Take over-the-counter or prescription medicine?
<input type="checkbox"/>	<input type="checkbox"/>	10. Surgical operation performed or been advised to have surgery performed?	<input type="checkbox"/>	<input type="checkbox"/>	20. Illness, injury, birth defect, congenital defect, disease or disorder not mentioned in questions 1 through 19?

Give details to "yes" answers indicated on the reverse side of the application.

