



KAISER PERMANENTE

Kaiser Foundation Health Plan
Of the Mid-Atlantic States, Inc.
2101 E. Jefferson Street
Rockville, MD 20852

MEDICAL QUESTIONNAIRE
Employee and Enrolling Dependent(s)

Section I Employer Information

Employer Name			Group Number (if assigned)	
Address	City	State	Zip	Telephone

Section II LIST ALL PERSONS TO BE COVERED

Name	Relationship to Employee	Sex	Date of Birth	Social Security Number	Height	Weight
	EMPLOYEE					

If additional persons are to be listed, please complete separate Questionnaire.

SECTION III All questions must be answered. Otherwise your application will not be processed. Any material misrepresentation may void your coverage from the effective date.

Please respond to each question below by **CHECKING** the appropriate answer. Provide a full explanation in **Section IV** of all questions answered "Yes" below.

Has any person named in this application suffered from, been diagnosed with, or treated for, any of the following conditions within the last **five (5)** years?

	Yes	No		Yes	No
1. AIDS, ARC (AIDS related Complex), or HIV Positive Status	<input type="checkbox"/>	<input type="checkbox"/>	14 Cysts, tumors, or growths	<input type="checkbox"/>	<input type="checkbox"/>
2. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	15 Cirrhosis, Disease or Disorders of the Liver	<input type="checkbox"/>	<input type="checkbox"/>
3. Anemia, Blood Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	16 Colitis, Diverticulitis, Intestinal Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
4. Anorexia / Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	17 Convulsions or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis, joint discomfort, gout	<input type="checkbox"/>	<input type="checkbox"/>	18 Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma, chronic bronchitis, emphysema or pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	19 Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>
7. Back, Spine, or Bone Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	20 Extremity or Limb Injuries or Disorders	<input type="checkbox"/>	<input type="checkbox"/>
8. Birth Defects, deformity or handicap	<input type="checkbox"/>	<input type="checkbox"/>	21 Kidney Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
9. Bladder/Urinary System Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	22 Lung / Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
10. Blood Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	23 Lupus	<input type="checkbox"/>	<input type="checkbox"/>
11. Brain Disease or Disorder, Concussion/Head Injury, Headaches	<input type="checkbox"/>	<input type="checkbox"/>	24 Muscular Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
12. Breast Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	25 Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
13. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	26 Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>

Please respond to each question below by **CHECKING** the appropriate answer. Provide a full explanation in **Section IV** for all questions answered “**Yes**” below.

Has any person named in this application suffered from, been diagnosed with, or treated for, any of the following conditions within the last **five (5)** years?

	Yes	No		Yes	No
27 Nervous System Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	32 Stroke	<input type="checkbox"/>	<input type="checkbox"/>
28 Pancreatic Disorder, Pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>	33 Stomach, Intestinal or Digestive Disease	<input type="checkbox"/>	<input type="checkbox"/>
29 Paralysis, Paraplegia, Quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>	34 Thyroid or Glandular Disease / or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
30 Reproductive System Disorder	<input type="checkbox"/>	<input type="checkbox"/>	35 Vascular or Circulatory Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>
31 Skin Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

36. Within the last **five (5)** years, has any person named in this application been hospitalized, operated on or been advised to have an operation which has not been performed? Yes _____ No _____

37. Within the last **five (5)** years, has any person named in this application had a sexually transmitted disease? Yes _____ No _____

Has any person named in this application suffered from, been diagnosed with, or treated for any of the following conditions within the last **ten (10)** years?

	Yes	No		Yes	No
38 Alcohol, Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	42 High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
39 Cancer, Lymphoma, Leukemia or Malignancy	<input type="checkbox"/>	<input type="checkbox"/>	43 Mental or Behavioral Disorders, Anxiety, Depression, Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>
40 Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	44 Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
41 Heart Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>			

45. Does any person named in this application **currently** take prescription medications? Yes _____ No _____
If “**Yes**”, indicate medication(s), reason for taking and dosage per day in **Section IV**.

46. Within the last **ten (10)** years, has any person named in this application ever been rejected for coverage or coverage terminated by any insurance company? Yes _____ No _____

47. Within the last **ten (10)** years, has the applicant been rejected or discharged from military duty because of health or for any nervous condition? Yes _____ No _____

48. Is any person named in this application **currently** disabled? Yes _____ No _____

SECTION V Please complete the appropriate section if you or any person named in this application have/has any of the following diagnoses: Hypertension, Diabetes, Cancer, or Pregnancy.

Hypertension (within the last ten (10) years)

Name	Date first diagnosed	Most recent blood pressure reading including the date		Please provide name, dosage and frequency of all prescribed medications
		Reading:	Date:	

Diabetes (within the last ten (10) years)

Name	Date first diagnosed	Type of Diabetes (Type I/Type II)	Please provide name, dosage and frequency of all prescribed medications

Have any test results **within the last ten (10) years** (for cardiac, renal or retinal disorders) been abnormal?

Yes _____ No _____ If "Yes", please explain:

Cancer (within the last ten (10) years)

Name	Date initially diagnosed	Please provide the specific type of cancer

Has any surgery ever been performed?

Yes _____ No _____ If "Yes", give dates and types of surgery

Are you currently receiving, or have you ever received radiation therapy or chemotherapy?

Yes _____ No _____ If "Yes", give expected date(s) of completion or treatment completion date

Pregnancy: Is any person named in this application currently pregnant? Yes _____ No _____

Name	At what stage of pregnancy?	Expected Due Date	Is this a high-risk pregnancy? Yes _____ No _____ (If "Yes", please explain:
	<input type="checkbox"/> 3 rd Trimester (27-40 weeks) <input type="checkbox"/> 2 nd Trimester (14-26 weeks) <input type="checkbox"/> 1 st Trimester (1-13 weeks)		

Give the phone number of your current OB/GYN:

Has any person named in this application, within the last ten (10) years, have a premature birth or other complications with previous pregnancies and deliveries: Yes _____ No _____

If "Yes", please explain:

SECTION VI Authorization

I AUTHORIZE any physician, hospital, clinic or other medical care provider, insurance or reinsurance company, or Medical Reporting Bureau to release to this Health Plan copies of any Medical Records and information regarding any past or present mental or physical condition. I understand that a copy of this Authorization is as valid as the original and this Authorization is valid for:

- (1) 30 months from the date I (or Legal guardian if Applicant is a minor) sign the authorization with respect to initial coverage or re-enrollment of coverage; or,
- (2) The term of the policy from the date I (or legal guardian if Applicant is a minor) sign the authorization, with the respect to a claim.

I UNDERSTAND that I or any person authorized to act on my behalf is entitled to receive a copy of this form.

I UNDERSTAND that this information will be used to determine eligibility for Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. coverage and for other purposes related to such coverage. The coverage applied for will not become effective unless and until the Application is authorized by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

I CERTIFY that I have read or have had read to me, all the information contained on this questionnaire and such information I have provided is accurate and complete to the best of my knowledge. I certify that if I have made any material false statement, misrepresentation or omission on this questionnaire, which changes the risk, assumed by the Health Plan, I may lose coverage under this Health Plan.

I hereby apply for membership in Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. I certify that I shall update this medical questionnaire to include any condition or disease, which occurs after the date of submission of this application and prior to the Health Plan’s acceptance. Failure to provide information on any known condition or disease to the Health Plan constitutes a misrepresentation of the presence of a pre-existing condition or disease and may void the requested coverage.

Printed Name of Employee	Signature of Employee	Date
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WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.