



KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.
2101 East Jefferson Street, Rockville, MD 20852

Medical Questionnaire for Kaiser Permanente for Individual and Family Plans

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

Each family member applying for coverage must complete a questionnaire

Applicant's Name: Last _____ First _____ M.I. _____

Date of Birth: ___/___/___ Male ___ Female ___ Height: ___ft. ___in. Weight: _____

Section I For the following, check either yes or no. If you check yes for any question, you MUST explain in Section II

Have you suffered from, been diagnosed with, or treated for, any of the following conditions during the last **5** years?

	Y	N		Y	N
1. AIDS, ARC(AIDS-related Complex), or HIV Positive Status or other chronic or recurrent infectious condition(s)	<input type="checkbox"/>	<input type="checkbox"/>	18. Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
2. Alzheimer's disease	<input type="checkbox"/>	<input type="checkbox"/>	19. Cystic Fibrosis or any other genetic disease	<input type="checkbox"/>	<input type="checkbox"/>
3. Anemia, blood or immunological disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	20. Edema (swelling of the extremities)	<input type="checkbox"/>	<input type="checkbox"/>
4. Anorexia, bulimia or other eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	21. Extremity or limb injury or disorder	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis, gout or other condition affecting one or more joints	<input type="checkbox"/>	<input type="checkbox"/>	22. Kidney disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma, chronic bronchitis, emphysema, pneumonia or other chronic or recurrent lung or pulmonary condition	<input type="checkbox"/>	<input type="checkbox"/>	23. Lupus, scleroderma or any other connective tissue disorder	<input type="checkbox"/>	<input type="checkbox"/>
7. Back, spine, or bone disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	24. Muscular disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>
8. Birth defect, deformity or handicap	<input type="checkbox"/>	<input type="checkbox"/>	25. Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
9. Bladder or genitourinary system disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	26. Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
10. Oral or ENT (ear, nose, or throat) disorders including TMJ (temporomandibular) dysfunction, masticatory dysfunction, or orofacial deformity or other chronic disease or condition involving the ears, nose or throat	<input type="checkbox"/>	<input type="checkbox"/>	27. Nervous system disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>
11. Brain disease or disorder, concussion/head injury, headaches	<input type="checkbox"/>	<input type="checkbox"/>	28. Pancreas disorder, pancreatitis	<input type="checkbox"/>	<input type="checkbox"/>
12. Breast disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	29. Paralysis, paraplegia, quadriplegia	<input type="checkbox"/>	<input type="checkbox"/>
13. Cataract, iritis, glaucoma or eye disorder	<input type="checkbox"/>	<input type="checkbox"/>	30. Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
14. Cyst, tumor, or other growth	<input type="checkbox"/>	<input type="checkbox"/>	31. Skin disease or disorder or disfiguring scar	<input type="checkbox"/>	<input type="checkbox"/>
15. Cirrhosis, Hepatitis or other disease or disorder of the liver	<input type="checkbox"/>	<input type="checkbox"/>	32. Stroke or TIA (mini stroke)	<input type="checkbox"/>	<input type="checkbox"/>
16. Colitis, diverticulitis, intestinal disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>	33. Thyroid or glandular disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>
17. Convulsion or epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	34. Vascular or circulatory disease or disorder (including blockage and clot)	<input type="checkbox"/>	<input type="checkbox"/>

Medical Questionnaire for Kaiser Permanente Individual and Family Plans – page 2

Have you suffered from, been diagnosed with, or treated for, any of the following conditions during the last **10** years?

	Y	N		Y	N
35. Alcohol, Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	39. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
36. Cancer, lymphoma, leukemia or malignancy	<input type="checkbox"/>	<input type="checkbox"/>	40. Mental or behavioral disorder, anxiety, depression, attempted suicide	<input type="checkbox"/>	<input type="checkbox"/>
37. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	41. Tuberculosis (including exposure)	<input type="checkbox"/>	<input type="checkbox"/>
38. Heart disease or disorder	<input type="checkbox"/>	<input type="checkbox"/>			

Questions 42 through 49 must be completed for Females

- | | Y | N |
|---|--------------------------|--------------------------|
| 42. Has your initial menstrual cycle begun? | <input type="checkbox"/> | <input type="checkbox"/> |
| 43. Has menopause begun? | <input type="checkbox"/> | <input type="checkbox"/> |
| 44. Date of your last menstrual cycle: _____ (month/day/year)____/____/____ | | |
| 45. Have you been unable to become pregnant, undergone testing for infertility, or been treated in any way for infertility within the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 46. Are you pregnant at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 47. Have you had a high risk pregnancy in the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 48. Have you had any abnormality of the female organs or menstrual period or unexplained vaginal bleeding in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 49. Date of your last PAP test: _____ (month/day/year)____/____/____
Findings: Normal ___ Abnormal ___ Questionable ___ Never had a PAP test ___ | | |

Questions 50 through 57 must be completed by all applicants

50. Do you currently take prescription medications? Yes ___ No ___
(if yes, you must indicate the medication(s), reason(s) and dosage per day in Section II)
51. In the past 5 years have you been hospitalized, operated on, or advised to have an operation which has not yet been performed? Yes ___ No ___
52. Have you gained or lost more than 10 lbs. in the past year?
Yes ___ No ___
53. Have you smoked in the last 10 years?
Never Smoked ___ Smoked, but not in the last 3 years ___ Currently smoke, or smoked within the last 3 years ___
54. If you currently smoke (or have smoked within the past 10 years)
How many packs per/day? ___ How long have you smoked? _____ N/A_____
55. In the last 10 years have you ever been rejected by Kaiser Permanente or any health, accident, or life insurance company?
Yes ___ No ___
56. In the last 10 years have you been rejected or discharged from military duty because of health or for any nervous condition?
Yes ___ No ___
57. Do you have any other chronic or recurrent conditions not previously listed above? (if yes, please explain in Section II)
Yes ___ No ___

Medical Questionnaire for Kaiser Permanente Individual and Family Plans – page 4

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 and all Medical Records and information regarding any past (within 10 years) 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 that 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 that I (or Legal guardian if Applicant is a minor) sign the authorization, with 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 that 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.

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact a membership services representative before signing this application or card.

WARNING: IT IS A CRIME TO KNOWINGLY OR WILLINGLY 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.

Signature of Applicant (or Guardian if Applicant is a minor)

Date