

Individual Health Questionnaire

Employee's Name: Age: Enroll: If Ino, other coverage?				Employee Inforr	nation					
Spouse's Name: Age: Enroll: If no, other coverage? Number of Dependent Children: Age(s): Enroll: If no, other coverage? Employee's Height: ft. in. Spouse's Height: ft. in. Employee's Height: now; one year ago Spouse's Weight: now; one year ago Health Information Are you or your dependents afflicted or diagnosed with a major disease or illines? (if yes, explain below) YES NO Are you or your dependents anticipating any medical or surgical treatment in the next year? (if yes, explain below) YES NO Do you or your dependents currently take any prescription medication? (if yes, explain below) YES NO Have you or your dependents used any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents used any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents used any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents used any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed any type of tobseco product within the past 5 years? (if yes, explain below) YES NO Have you or your dependents sed you or your	Group Name:					YES	NO		YES	NO
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thereon.				Signature						
Employee Signature Date	I certify that the information thereon.	n stated above	e is true and o	orrect and acknowledge th	at any covera	age issu	ied by	the Plan will be issued in re	liance	
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