KVMA
Health and Wellness Plan

Corporate Plan Management
1220 SW Executive Drive
Topeka, KS 66615

HEALTH QUESTIONNAIRE

SECTION 1 - Employer Information:

Employer Name: _____ Date of Hire: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone #: _____ Email: _____

SECTION 2 - Employee Information:

Employee Name (Last, MI, First): _____ DOB: _____

Address: _____ Daytime Phone #: _____

City: _____ State: _____ Zip: _____

Job Title: _____

Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

SECTION 3 - Other Insurance Coverage (coverage in addition to the Section 1 Employer group coverage):

Are you or any dependents disabled? ____ Yes ____ No If yes, please indicate name(s) _____

D you or your spouse have other health insurance? ____ Yes ____ No _____

If yes, please indicate carrier name: _____

Name of policy holder: _____ List all covered dependents: _____

_____

SECTION 4 - Subscriber/Dependents (IMPORTANT: Include employee and all dependents):

FName, MI, LName	SSN	DOB	Age	M/F	Tobacco Use? Y/N

SECTION 5 - Health Plan Enrollment:

____ I decline participation ____ I elect to participate: ____ Employee Only ____ Employee/Spouse
____ Employee/Child(ren) ____ Family

SECTION 6 - Health Information

Employee: Height ___ feet ___ inches; Weight ____ Spouse: Height ___ feet ___ inches; Weight ____

1. Has any covered family member been diagnosed or treated for any of the following conditions in the past five (5) years? **(ONLY include those who will or could possibly be covered under this health plan)**

A.	Cardiac Disorder		Yes		No	H.	AIDS/Immune System Disorder		Yes		No
B.	Cancer (any form)		Yes		No	I.	Alcohol/Drug Abuse		Yes		No
C.	Diabetes		Yes		No	J.	Mental/Nervous Disorder		Yes		No
D.	Kidney Disorder		Yes		No	K.	Neuromuscular Disorder		Yes		No
E.	Respiratory Disorder		Yes		No	L.	Stomach/Gastrointestinal		Yes		No
F.	Liver Disorder		Yes		No	M.	Seizures/Convulsion/Epilepsy		Yes		No
G.	High Blood Pressure		Yes		No	N.	Arthritis/Back/Bone/Join Disorder		Yes		No

2. Has any covered family member had an application for insurance declined, postponed, rated, or otherwise modified? Yes ___ No ___

3. Has any covered family member had any medical conditions in the past 24 months requiring medical care, prescription management, or hospitalization in the amount of $5,000 or more? Yes ___ No ___

4. Are any covered family members anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? Yes ___ No ___ If Yes, please provide information below.

5. Are any covered family members currently pregnant or suspect they may be pregnant? Yes ___ No ___

If Yes to question 1, 2, 3, 4, or 5, please give detail in the space provided below.

Question Number	Family Member	Disease/Diagnosis /Treatment	Date of Onset Month/Year	Date Last Seen by Physician	Remaining Symptoms or Problems

6. Prescriptions/Medications - Please list any medications, prescriptions, or injections taken in the past 12 months.

Family Member	Medication/Rx/Injection	Dosage	Medical Condition

AUTHORIZATION: My signature below hereby authorizes any physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge pertaining to the health of me or my dependents listed on this form (Page 1, Sections 2 and/or 4) to proved such information to Corporate Pan Management (Health Plan Administrator). A photographic copy of this authorization shall be considered permissible. This authorization will remain in effect for six (6) months from the date below.

Employee Signature: _____ Date: _____