GBS Health Plans

Marketed and Administered Exclusively by:
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EMPLOYEE ENROLLMENT/PERSONAL HEALTH QUESTIONNAIRE (PHQ)

All questions must be answered or the form may not be accepted.

Please choose from the following: ❑ New Applicant ❑ Coverage Change ❑ Information Update ❑ COBRA Applicant ❑ Retiree

Employee Name:		Employer Name:	
Home Phone:		Work Phone:	
Address:		City:	State: ZIP Code:
Email Address:		Marital Status:	
Date of Hire:	Are you currently Full Time? ☐Yes ☐No	Average Hours Worked per Week:	
Occupation:	Is Spouse Employed? ☐Yes ☐No		

Are you planning to enroll in your employer's health insurance plan? ☐Yes ☐No

***If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of page 3.

☐ Covered by Spouse's Plan ☐ Do Not Want Coverage ☐ Not Eligible ☐ Other Reason _____

*If you selected "Yes", please complete the rest of this form.
*Answer the following questions for yourself and eligible enrolling family members. Include additional sheets for detailed explanations or additional dependents.

I. Demographic, Build and Tobacco Use

	Relation to Employee	Member Name	Social Security Number	Gender (M/F)	Date of Birth (mm/dd/yyyy)	Height Ft.	Height In.	Weight (lbs)	Home Zip Code	Tobacco Use (Yes/No)
1	Employee									
2	Spouse									
3	Child									
4	Child									
5	Child									
6	Child									

II. Coverage Information

MEDICAL PLAN	DENTAL PLAN	VISION PLAN	LIFE INSURANCE	SHORT TERM DISABILITY	LONG TERM DISABILITY
Plan: _____ ☐ Individual ☐ Individual & 1 Child ☐ Individual & Adult ☐ Individual & Children ☐ Family ☐ Comp. to Medicare (Ind. Only and Benefit Coverage Only, Not Eligible for HSA.) ☐ NONE	Plan: _____ ☐ Individual ☐ Individual & 1 Child ☐ Individual & Adult ☐ Individual & Children ☐ Family ☐ NONE	Plan: _____ ☐ Individual ☐ Individual & 1 Child ☐ Individual & Adult ☐ Individual & Children ☐ Family ☐ NONE	☐ Life Insurance/AD&D ☐ Supplemental Life Benefit: _____ ☐ Dependent Life ☐ NONE	☐ Short Term Disability ☐ Voluntary STD Benefit: _____ ☐ NONE	☐ Long Term Disability ☐ Voluntary LTD ☐ NONE

Life Insurance Beneficiary

Beneficiary Name	Relationship	%

III. Medical Conditions and Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following? ***Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on page. 3 for ALL "YES" answers.

1. Cancer (if yes, list location and type of cancer below ☐Yes ☐No
   Location and type of cancer
   Check One: ☐Stage 1 ☐Stage 2 ☐Stage 3 ☐Higher
   Date of Remission: (If Applicable)
2. Cardiac or Heart Disease/Disorder ☐Yes ☐No
   If YES, check all that apply:
   ☐heart attack
   ☐bypass surgery or angioplasty on single vessel, or
   ☐bypass surgery or angioplasty on multiple vessels;
   ☐ANY other heart conditions (list here)
   (i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)
3. Diabetes (if yes, list type 1 or 2) ☐Yes ☐No
   Type:
   If yes, list 3 most recent HbA1c/fasting blood sugar levels:
   1) 2) 3)
4. High Cholesterol ☐Yes ☐No
   If yes, list 3 most recent readings:
   1) 2) 3)
5. High Blood Pressure ☐Yes ☐No
   If yes, list 3 most recent readings:
   1) 2) 3)
6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout) ☐Yes ☐No
7. Autoimmune Disease (i.e. lupus, MS, anemia) ☐Yes ☐No
8. Back Disorder (i.e. degenerative disk disease) ☐Yes ☐No
   Herniated disk, spinal fusion, spondylitis, strain)
9. Benign Growth (i.e. tumor, cyst) ☐Yes ☐No
10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis) ☐Yes ☐No
11. Circulatory System Disease (i.e. stroke, arterial/vascular Diseases) ☐Yes ☐No
12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia) ☐Yes ☐No
13. Kidney Disorder (i.e. nephritis, renal failure) ☐Yes ☐No
14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E) ☐Yes ☐No
15. Mental Illness (i.e. mild or major depression, anxiety, Bipolar disorder or schizophrenia) ☐Yes ☐No
16. Counseling Current or Prior Counseling? ☐Yes ☐No
17. Muscular Disorder ☐Yes ☐No
18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, Emphysema, bronchitis) ☐Yes ☐No
19. Stomach (i.e. ulcer, acid reflux, GERD) ☐Yes ☐No
20. Substance Dependency (i.e. alchohol, drug) ☐Yes ☐No
21. Transplants (if yes, list organ(s) below: ☐Yes ☐No

22. Is anyone currently taking prescription medication(s)? ☐Yes ☐No
23. Has anyone had any of the following for a serious illness in the past 5 years?
    a) treatment ☐Yes ☐No
    b) hospitalization ☐Yes ☐No
    c) surgery ☐Yes ☐No
24. Is anyone currently:
    a) hospitalized or confined in a treatment facility ☐Yes ☐No
    b) confined at home, incapacitated or incapable of self-support? ☐Yes ☐No
25. Is any of the following pending?
    a) treatment (medical treatment or diagnostic testing) ☐Yes ☐No
    b) hospitalization ☐Yes ☐No
    c) surgery ☐Yes ☐No
26. In the past 5 years, has anyone enrolling had symptoms of any serious medical condition not yet indicated on this form? ☐Yes ☐No

IV. Pregnancy and Childbirth

27. Is anyone pregnant? ☐Yes ☐No
    a) The due date is _____
    b) Is this a High Risk Pregnancy, any complications or bleeding? ☐Yes ☐No
    c) Previous C-Section or pre-term birth? ☐Yes ☐No
    d) Are multiple births expected? If so, please check ☐Twins ☐Triplets ☐More ☐Yes ☐No

*If you marked "Yes" to any item on Pages 1 & 2, please complete ADDITIONAL DETAIL TABLE below, or this form will not be accepted.

ADDITIONAL DETAIL TABLE – Please Fill in Details Below for All Questions Answered "YES"

Question #	Name of Individual	Condition/Diagnosis	Date of Onset	Last Date Treated	Treatment/Drug	Still Taking (Y/N)	Degree of Recovery

My signature declares that the answers and information presented on this application are complete and true for all Applicants to the best of my knowledge and belief, and this information will be used as the basis for underwriting. NOTICE: A person who knowingly and with intent to misrepresent on this application or statement of claim containing any false, incomplete or misleading information may be subject to denied claims.

I understand that the following parties may need to provide or collect information on me or my Dependent Applicants: Group Benefit Services, Inc. (GBS) and its reinsurers, any insurance support organization, related Business Associates, any consumer reporting agency, physicians, hospitals, clinics, and all persons authorized to represent these organizations for this purpose. I authorize any health care provider, hospital or medically related facility, pharmacy, or pharmacy related facility, consumer reporting agency, insurance or reinsurance company, having information about me or any of my Dependent Applicants to provide all such information as requested by GBS or its Business Associates or Agents.

I understand that this Authorization may be needed for the purpose of gathering information to make eligibility, underwriting and group rating determinations and includes any and all information regarding diagnosis, treatment, and prognosis or medical conditions including physical, mental, psychiatric, drug, alcohol, and prescription history. Unless revoked earlier, this Authorization will be valid for thirty (30) months after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to GBS.

This enrollment form should not be completed more than 60 days prior to the Plan Sponsor's requested effective date. Date Signed: _____

Print Name _____ Applicant Signature: _____