Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:
(must submit by mail if enclosing a check or money order)

Health Plan One
1000 Bridgeport Ave. 4th FL
Shelton, CT 06484

Fax (Toll Free): 888.342.1612

Any questions? Please call Health Plan One at 1-877.567.5267. Thank you!

GroupHealth

Individual & Family plan application

Thank you for considering coverage through one of our Individual & Family plans. Coverage for these plans is provided by Group Health Cooperative or Group Health Options, Inc. ("Group Health" refers to both carriers, unless otherwise noted.)

To be considered for enrollment, please complete this application in black or blue ink only. This application and the necessary supporting documents must be **received by the 20th of the month** for coverage to begin the first of the following month. Incomplete or inaccurate information may delay the effective date of coverage.

Send the application and supporting documents to:

Group Health Individual & Family Plans
320 Westlake Ave N Suite 100
Seattle WA 98109-5233

If you have any questions about this application or the process, please call us at 1-800-358-8815 or 206-448-4141.

CHECKLIST

- ☐ **Signature (required):** This application has been signed by myself and my spouse/domestic partner (if applicable).
- ☐ **Payment (required):** The first month's premium payment is being made by including my credit card information on this application or enclosing a check or money order.
- ☐ **Documentation (required, if applicable):** I am enclosing any and all documentation as required in Section 7, including a copy of the Standard Health Questionnaire for all persons listed on this application (unless exempt).
- ☐ **Automatic transfer of funds (optional):** After the first month, I've requested premium payments be transferred from my banking institution and have enclosed the Transfer of Funds form.

ELIGIBILITY

Applicants must meet both of these requirements.

- ☐ Washington state is my principle residence and I reside within one of the following counties: Benton, Columbia, Franklin, Grays Harbor (98541, 98557, 98554, and 98568), Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman, or Yakima.
- ☐ I am not eligible for Medicare.

HOW DID YOU HEAR ABOUT GROUP HEALTH?

☐ Group Health group plan	☐ Television	☐ Word of mouth	☐ Other: ________________
☐ Web site	☐ Seminar	☐ Broker/agent	
☐ Newspaper	☐ Direct mail	☐ Radio	

SECTION 1. APPLICATION TYPE

☐ This is for new enrollment. I wish coverage to begin on the first day of: ______________________ (month/year)

I am a current Individual & Family plan member and I am:
(please check the boxes below that apply)

Changes:

☐ Changing I&F plans**

☐ Changing from dependent to subscriber

Adding eligible dependents (complete sections 2, 6, 7, and 8):

☐ Adding a newly adopted child Date of event: ______________

☐ Adding a spouse/domestic partner

☐ Adding a dependent child

☐ Adding a newborn Date of birth: ______________

**Changing from a Group Health Cooperative plan to a Group Health Options, Inc. plan will require completion of a new Standard Health Questionnaire. If you are changing from one Group Health Cooperative plan to another Group Health Cooperative plan, you may be required to complete a new Standard Health Questionnaire. Call Customer Service at 1-888-901-4636 for more information.

SECTION 2. ADDRESS AND BILLING INFORMATION

Group Health ID Number (if current or prior member)	Name: Last, first, middle initial	Sex M/F	Date of birth	Social Security # (REQUIRED)	Have tobacco products been used during the last 12 months?
	Applicant/subscriber				☐ Yes ☐ No
	Spouse/domestic partner				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No
	Dependent child (under 25)				☐ Yes ☐ No

Street address	City	State	ZIP	County
Mailing address	City	State	ZIP	Home telephone number
Guarantor name, if applicable				E-mail address (optional)
Guarantor billing address	City	State	ZIP	Guarantor telephone number

SECTION 3. HOW TO PAY

Payment option:

☐ Monthly statement (by mail) ☐ Automatic Transfer of Funds (electronic)

First month's premium must be paid by credit card, check, or money order. We accept Visa, MasterCard, or Discover.

- Please complete the Bankcard Payment form if paying with a credit card. Or, include a check or money order and return with this application.
- Monthly transfer of funds from bank (optional). *First month's premium must be paid by credit card, check, or money order.*
  - Please complete and send a Transfer of Funds form with this application.

Note: After your first premium payment, you will receive a monthly statement, unless you have arranged to have funds transferred from your financial institution.

SECTION 4. PLAN CHOICES

Check one box to indicate your health plan selection:

Group Health Cooperative:

- ☐ The Welcome **500** Plan – '08
- ☐ The Welcome **1750** Catastrophic Plan – '08*
- ☐ The Welcome **3500** Catastrophic Plan – '08*

Group Health Options, Inc.:

- ☐ The Balance **1000** Plan – '08
- ☐ The Balance **1500** Plan – '08
- ☐ The Balance **2500** Catastrophic Plan – '08*
- ☐ The Balance **5000** Catastrophic Plan – '08*
- ☐ HealthPays® Health Savings Account (HSA)
  2000 Individual/**4000** Family Catastrophic Plan – '08*†

Note: Federal law places some limitations on HSA eligibility. Consult your tax advisor or materials available through the U.S. Treasury Dept. for this important information to make sure you're selecting the right HSA plan for your family.

*These plans provide catastrophic coverage. If you decide at a later date to switch to a plan that provides greater coverage, you may be asked to provide a new Standard Health Questionnaire. In addition, your prior catastrophic coverage may not meet creditable coverage requirements for pre-existing conditions.

†Children under age 18 cannot enroll as the primary applicant/subscriber.

SECTION 5. ADDITIONAL OPTIONS

☐ I would like Washington Dental Service dental coverage for myself and all eligible dependents. The address of WDS is: 9706 Fourth Ave. N.E., Seattle, WA 98115-2157. **Note:** If you waive dental coverage, you will not be able to reapply until your renewal period.

☐ I would like Group Health Cooperative voting membership for myself and all eligible dependents.

SECTION 6. PRIOR OR CURRENT COVERAGE

Group Health's Individual & Family plans have a nine-month waiting period on coverage for pre-existing conditions. If you are coming from a noncatastrophic health plan with no more than a $1,750 deductible and with maternity and prescription drug benefits, we will waive or reduce the waiting period. If you had a 64-day or more break in coverage, no waiver or reduction will be applied and you can skip to Section 7.

The pre-existing condition wait period will be waived if you are an "eligible individual" under HIPAA. You qualify as an "eligible individual" if: you have 18 months or more of creditable coverage without a break of 63 full days or more before applying for coverage with Group Health; your most recent coverage was under a group health plan, governmental plan, or church plan (or under health insurance coverage offered in connection with such a plan); you are not eligible for a group health plan; you are not eligible for Medicare or Medicaid; you do not have other health insurance; you did not lose your most recent coverage because of non-payment of premiums or fraud; and you elected and used up your available COBRA continuation coverage.

If you have/had previous coverage other than Group Health within the last 63 days, provide your Certificate of Creditable Coverage or other document showing your beginning and ending dates of coverage (when available) with this application so we may determine if a reduction of the wait period applies.

1. Name of insurance company: ______________________ Phone: (   ) ______________
   (Any company, including Group Health Cooperative or Group Health Options, Inc.)
2. Names of all enrollees on current/previous coverage: ______________________________
   ____
3. Date coverage began: ______________ Date coverage ended: ____________
4. Deductible amount per year: Individual ____________ Family ____________
5. Did/does your coverage include: ☐ Maternity ☐ Prescription drug ☐ Hospital only
6. Are you currently on or coming from COBRA: ☐ Yes ☐ No Began: __________ Ended:____________
7. What type of coverage are you coming from:

☐ Individual plan	☐ Group plan	☐ Federal plan (FEHBP/TriCare/Peace Corps Act)
☐ Healthy Options plan (DSHS)	☐ WSHIP	☐ College/school/short-term insurance
☐ Indian Health Service or tribal organization	☐ Basic Health plan	☐ State Children's Health Insurance Program (SCHIP)

SECTION 7. STANDARD HEALTH QUESTIONNAIRE EXEMPTIONS

Are you exempt from health screening? If so, check your reason below. Otherwise, you must submit a Standard Health Questionnaire for everyone listed on this application.

- ☐ **Relocation:** Applicant has relocated within Washington in the past 90 days, and prior health plan is not available. (Attach copy of recent utility bill.)
- ☐ **COBRA:** COBRA coverage exhausted within 90-days of application. [Include a letter from COBRA Administration and Certificate of Creditable Coverage – "COC."]
- ☐ **COBRA termination:** Former employer went out of business while on COBRA; application dated within 90-day of termination. (Include a verification letter.)
- ☐ **Provider cancellation:** Health care provider left network of our current individual plan within the last 90 days.
- ☐ **Employer exempt from COBRA:** Applying for coverage within 90 days of termination of a group health plan (including church plans) that is exempt from offering COBRA coverage and was enrolled for at least 24 continuous months. (Include letter of verification from employer or COC.)
- ☐ **Washington Basic Health plan:** Applying for coverage within 90 days of termination of the BH plan and was enrolled for at least 24 continuous months. (Include letter of verification from Basic Health.)
- ☐ **New child:** Addition of newborn or newly adopted child to an existing plan, within 60 days of event.

SECTION 8. ACKNOWLEDGEMENTS & SIGNATURES

This application becomes part of my Medical Coverage Agreement with Group Health. I understand that I have the right to examine and return the Medical Coverage Agreement within 10 days of receipt. I have read and agree to the Terms and Conditions included with this application and with the statements below.

- ☐ The signatures shown below allow me, my spouse/domestic partner, or my broker/agent (Section 9) to release to Group Health information about any person listed on my Individual & Family plan application documents, including information from the Standard Health Questionnaire. I further understand that under the Health Insurance Portability and Accountability Act (HIPAA), Group Health may only be allowed to release limited information to me, my spouse/domestic partner, adult/minor children, or my broker/agent.
- ☐ Group Health may collect, use, or disclose the Nonpublic Personal Information of persons listed on this application as required or permitted by law and to conduct routine business functions such as determining eligibility for enrollment, reviewing prior coverage for waiting periods, paying claims and, if appropriate, coordinating benefits, and fulfilling other legal obligations specified in my Group Health Medical Coverage Agreement.
- ☐ If my/our physical residential address changes to a different county in the Group Health service area, my premium rates may be subject to change.

I declare that, to the best of my knowledge, all information I have provided with this application is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that if I have made intentionally false or misleading statements on behalf of myself or any family members, the Medical Coverage Agreement may be cancelled retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines, and denial of benefits.

Applicant/guarantor signature **Date**

Spouse/domestic partner signature **Date**

SECTION 9. BROKER INFORMATION

William C. Stapleton

Group Health sales representative or broker or agent name

Health Plan One

Company/house name (if applicable)

B6985

Group Health agent ID number

B6985

Group Health house ID number

877-567-5267

Phone number

It is a crime to knowingly provide false, incomplete, or misleading information for the purpose of fraudulently obtaining health coverage. Penalties may include imprisonment, fines and denial of benefits.

GroupHealth

Individual & Family plan
Transfer of funds for monthly premium payment

Mail completed form to: Membership Accounts, P.O. Box 34750, Seattle, WA 98124-1750

I hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate fund transfers from my depository financial institution (bank) account indicated below and authorize my bank to honor these transfers.

Subscriber name			
Subscriber address			
City		State	ZIP
Subscriber number		Group number	
Bank name		Branch	
City		State	ZIP
Bank account number	Bank routing number	☐ Checking	☐ Savings
Name(s) listed on account			

If you would like to cancel your transfer of funds please check this box and sign below. ☐

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

Payment will be deducted between the seventh and tenth day of each month for the current month's premium.

I agree to indemnify and hold harmless Group Health Cooperative or Group Health Options, Inc., their officers, directors, employees, and agents, for any claims arising out of transfers or deductions from my account in accordance with this agreement.

I have read and understand the terms and conditions printed on the back of this page.

Signed Date

Signed Date

Return this copy

Terms and conditions of agreement for automated payment plan

1. I understand that this agreement will remain in effect until Group Health* has received written notice from me that it should be cancelled. Notice of cancellation must be received by Group Health by the thirteenth day of the month to cancel this agreement effective the first day of the following month.

2. I further understand that I have the right to stop payment of a transfer from my depository financial institution (bank) account to Group Health. Notice of stop-payment to my bank must be made at least three working days before the seventh working day of the month. This notice will automatically cancel this agreement.

3. If no funds are transferred from my bank account to Group Health due to insufficient funds, I understand that to keep this agreement in force my account will be debited for the balance due, on or before the next automatic withdrawal date.

4. I understand the amount of transfer will change at the annual rate renewal, and that notice of this annual monthly dues change will be mailed to the address of record thirty days prior to its effective date.

5. I understand that I will not receive notice of change in the amount of a transfer, which may vary from the previous month due to the addition or deletion of persons enrolled under this agreement.

6. I understand that if I transfer my current enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group, this agreement is automatically cancelled.

7. I understand that if I transfer my current enrollment to another Group Health individual plan, this agreement is automatically cancelled, and I will be required to complete another Individual & Family Plan Transfer of Funds for Monthly Premium Payment agreement.

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.

Individual & Family plan
Transfer of funds for monthly premium payment

Mail completed form to: Membership Accounts, P.O. Box 34750, Seattle, WA 98124-1750

I hereby authorize Group Health Cooperative or Group Health Options, Inc. to initiate fund transfers from my depository financial institution (bank) account indicated below and authorize my bank to honor these transfers.

Subscriber name		
Subscriber address		
City	State	ZIP
Subscriber number	Group number	
Bank name	Branch	
City	State	ZIP
Bank account number	Bank routing number	☐ Checking ☐ Savings
Name(s) listed on account		

If you would like to cancel your transfer of funds please check this box and sign below. ☐

Please attach a VOIDED CHECK or SAVINGS DEPOSIT SLIP here.

Payment will be deducted between the seventh and tenth day of each month for the current month's premium.

I agree to indemnify and hold harmless Group Health Cooperative or Group Health Options, Inc., their officers, directors, employees, and agents, for any claims arising out of transfers or deductions from my account in accordance with this agreement.

I have read and understand the terms and conditions printed on the back of this page.

Signed Date

Signed Date

Keep this copy for your records.

Terms and conditions of agreement for automated payment plan

1. I understand that this agreement will remain in effect until Group Health* has received written notice from me that it should be cancelled. Notice of cancellation must be received by Group Health by the thirteenth day of the month to cancel this agreement effective the first day of the following month.

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5. I understand that I will not receive notice of change in the amount of a transfer, which may vary from the previous month due to the addition or deletion of persons enrolled under this agreement.

6. I understand that if I transfer my current enrollment to a Group Health Cooperative or Group Health Options, Inc. employer group, this agreement is automatically cancelled.

7. I understand that if I transfer my current enrollment to another Group Health individual plan, this agreement is automatically cancelled, and I will be required to complete another Individual & Family Plan Transfer of Funds for Monthly Premium Payment agreement.

*Group Health refers to Group Health Cooperative or Group Health Options, Inc.

GroupHealth

Individual & Family plan bankcard payment

The first month's premium for your Group Health* Individual & Family plan must be paid by credit card, check, or money order. We accept Visa, MasterCard, or Discover.

☐ Visa ☐ MasterCard ☐ Discover

________ - ________ -________ -________ ________

Card # Expiration date

____

Name on card (please print)

Individual & Family Plan Sales

800-358-8815

Note: Payment will not be processed until Individual & Family coverage is approved.

OFFICE USE ONLY

Date________________ ☐ Send receipt

____

Daytime phone number

____ ________________________

Subscriber name Subscriber #

____ ________________________

Group # Payment amount

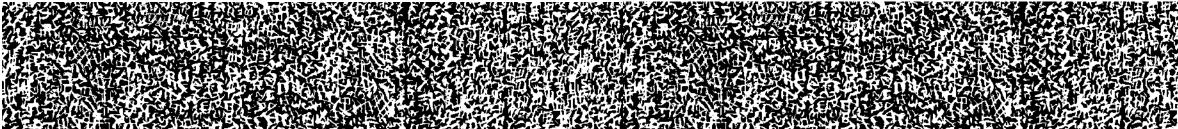
* Refers to Group Health Cooperative or Group Health Options, Inc.

GroupHealth

Individual & Family plan bankcard payment

The first month's premium for your Group Health* Individual & Family plan must be paid by credit card, check, or money order. We accept Visa, MasterCard, or Discover.

☐ Visa ☐ MasterCard ☐ Discover



Name on card (please print)

Individual & Family Plan Sales
800-358-8815

Note: Payment will not be processed until Individual & Family coverage is approved.

OFFICE USE ONLY

Date____________________ ☐ Send receipt

Daytime phone number

Subscriber name

Subscriber #

Group #

Payment amount

* Refers to Group Health Cooperative or Group Health Options, Inc.

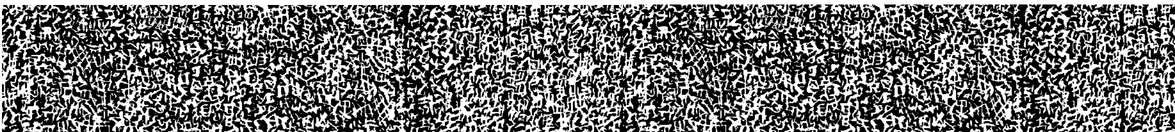
MEMBERSHIP COPY

GroupHealth

Individual & Family plan bankcard payment

The first month's premium for your Group Health* Individual & Family plan must be paid by credit card, check, or money order. We accept Visa, MasterCard, or Discover.

☐ Visa ☐ MasterCard ☐ Discover



Name on card (please print)

Individual & Family Plan Sales
800-358-8815

Note: Payment will not be processed until Individual & Family coverage is approved.

OFFICE USE ONLY

Date____________________________ ☐ Send receipt

Daytime phone number

Subscriber name

Subscriber #

Group #

Payment amount

* Refers to Group Health Cooperative or Group Health Options, Inc.

CUSTOMER COPY

WSHIP Washington State Health Insurance Pool

STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Recertified for Coverage Beginning On or After April 1, 2008

Revised for Use On and After July 26, 2009, In Compliance with ESHB 1401 Enacted by the 2009 Washington State Legislature

TURN PAGE TO BEGIN THE QUESTIONNAIRE ►

ARE YOU EXEMPT FROM TAKING THIS QUESTIONNAIRE?

Answer the following questions before you fill out the questionnaire *to determine if you meet one of these exemptions.*

If you do not know the answer *to a question,* ***do not fill out this questionnaire****. Please contact your agent or health carrier to whom you are applying for further instructions.* You may be asked to provide further documentation to support your responses to the following questions.

If you answer "Yes" *to any of the following questions,* ***do not complete the health questionnaire.*** You may apply to the health carrier without taking the questionnaire.

If you answer "No" *to all of the following questions****, this page must be completed along with Sections II and III of the questionnaire.*** *Submit the completed questionnaire to the health carrier with your application.*

Question	Yes	No
1. **Are you eligible for Medicare?**	Yes ○	No ○
2. **Have you changed residences from one part of Washington state to another part where your current health plan is not offered, and you are submitting your application within 90 days of relocation?**	Yes ○	No ○
3. **Is your health care provider no longer part of the provider network on your current individual health plan?** To answer yes, all of the following must be true: a. Your health care provider is on the new health plan you are applying for; and b. You received services from that provider during the 12 months before he or she left your current health plan; and c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network.	Yes ○	No ○
4. **Are you applying for individual health coverage within 90 days of using up your COBRA* coverage?** (This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.) To answer yes, you must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium.	Yes ○	No ○
5. **Have you been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event?**	Yes ○	No ○
6. **Are you applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination?** (Not applicable to BHP applicants.)	Yes ○	No ○
7. **Are you applying for individual health coverage within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event but you choose not to take COBRA coverage?** (Not applicable to BHP applicants.)	Yes ○	No ○
8. **Have you been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment?**	Yes ○	No ○
9. **Are you adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days?**	Yes ○	No ○

* COBRA refers to the federal law that requires certain employers to continue health coverage temporarily for certain former employees, retirees, spouses and dependents, at their expense when coverage is lost due to certain specific events. For more information about COBRA rules, go to the U.S. Dept. of Labor website: http://www.dol.gov/ebsa/faqs

TURN PAGE TO CONTINUE ►

SECTION I. INFORMATION ABOUT THE HEALTH QUESTIONNAIRE

YOUR PRIVACY RIGHTS

- By completing this form, you are giving your medical information to the insurance carrier. Under Washington State RCW 48.43.021, except as otherwise required by statute or rule, a carrier and the Washington State Health Insurance Pool (WSHIP), and persons acting at the direction of or on behalf of a carrier or WSHIP, shall not disclose an applicant's personally identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. Each carrier issues its own "consumer privacy statement" and maintains its own privacy policies.

INFORMATION ABOUT THE STANDARD HEALTH QUESTIONNAIRE

- The Standard Health Questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is used by insurance carriers to determine the eligibility of people who apply for private, individual medical coverage.
- If you are applying for family coverage, a separate questionnaire must be completed for each family member.
- Do not send medical records with this questionnaire. The carrier is not allowed to consider any medical information except what you provide on this questionnaire. If you are rejected for coverage and appeal the rejection, the carrier may then request further medical information which you may choose to provide if you believe it will assist the carrier in correctly scoring your questionnaire.
- Any time you apply for individual coverage, or change from one carrier to another, a new health questionnaire will be required unless you are exempt from taking the questionnaire (see the list on the previous page, page 2).
- Your signed questionnaire will be valid for a 90-day period. If you wait more than 90 days to submit your application, you will have to complete a new health questionnaire.

SCORING YOUR HEALTH QUESTIONNAIRE

- The insurance carrier uses a standard scoring system designed by WSHIP to score your questionnaire.
- The scoring system document can be viewed and printed from WSHIP's website, https://www.wship.org/shq.asp; the scoring document is also available from the carrier you are applying to or from your insurance agent.
- **Questions about the scoring of your questionnaire must be directed to the insurance carrier you are applying with, or your insurance agent, but not to WSHIP.**

IF YOU ARE DENIED COVERAGE BECAUSE OF YOUR SCORE

- If the carrier rejects your application because of your score you must be sent a rejection notice within 15 business days after the carrier has received your completed application and health questionnaire. To be "complete" this questionnaire must be signed and dated with no missing information that might affect your score.
- The carrier will mail you information about coverage available through WSHIP. WSHIP was established by the state legislature to offer insurance coverage for state residents who are rejected for coverage in the individual market. Your insurance agent can also provide this information to you, or you can contact WSHIP toll-free at 1-800-877-5187, or at www.wship.org. **You must apply for WSHIP coverage within 90 days of the date your notice of rejection from the carrier is postmarked in order to be eligible to enroll in WSHIP.**
- You may request an appeal of your score as described below.

HOW TO APPEAL YOUR SCORE

- You may request a review of your score if you think the carrier did not score your questionnaire correctly or did not respond within the required timeframe.
- To request a review of your score, **contact the insurance carrier directly in writing. Do not contact WSHIP to appeal your score.**
- You may apply for coverage with WSHIP during the time that your appeal is under review. (See contact information below).
- If the carrier does not complete its review of your appeal within 30 calendar days of their receipt of your appeal request, or if you have exhausted your appeal rights with the insurance carrier, you may request a review from WSHIP.
- WSHIP's review is limited to whether the carrier correctly applied the scoring system for the questionnaire and whether the carrier's notice of rejection for coverage was provided or postmarked within 15 business days of the carrier's receipt of your completed application.
- Within five business days of receipt of your request, the WSHIP administrator will respond to you confirming receipt of your request, the date it was received, the nature of the complaint and the resolution requested.
- Send your written request for review to WSHIP along with:
  - A copy of your completed health questionnaire;
  - The carrier's score of your questionnaire;
  - A copy of your written appeal request to the carrier; and
  - A copy of the carrier's written denial of your appeal, if applicable.
- Mail to: Appeals, WSHIP, P.O. Box 1090, Great Bend, KS 67530. A copy of WSHIP's operating rules governing requests for health questionnaire reviews is available at https://www.wship.org/appeals.asp or call the WSHIP Administrator toll-free at 1-800-877-5187.
- WSHIP will investigate your appeal and make its decision within 30 days of receipt of the complete information needed to respond to the appeal. WSHIP will notify you and the carrier of its decision.
- Contact WSHIP if you wish to enroll with WSHIP during your appeal review period.

TURN PAGE TO CONTINUE ►

DEFINITIONS: The following is a **list of terms** used in this questionnaire. These definitions will help you fill out the questionnaire, if you do not understand any terms used.

- **Acute** (as opposed to **Chronic**)**:** Typically sudden onset, and resolving after a single course of treatment or therapy. Many are infectious in origin. Examples include pneumonia, gastritis, urinary tract infections, and minor trauma not requiring surgery.

- **Benign** (as opposed to **Malignant**) implies a mild and non-progressive disease.

- **Chronic** (as opposed to **Acute**)**:** A repetitive illness, that may or may not improve over time. Chronic illnesses can last from weeks to years. Examples include heart failure, COPD, leukemia, and many of the psychiatric illnesses such as depression and schizophrenia.

- **Diagnosed** means a medical condition or disease has been identified by a licensed physician or medical professional who has a license to practice medicine.

- **Major** (as opposed to **Minor**)**:** These illnesses frequently require the use of many medications and if not addressed promptly and thoroughly, can lead to serious long-term complication and possibly death. Many evolve into chronic illnesses. Examples include coronary heart disease, Type 1 diabetes, stroke, and renal (kidney) failure.

- **Malignant** (as opposed to **Benign**) is a medical term used to describe a severe and progressively worsening disease.

- **Medicated** means you are taking a drug prescribed by a licensed physician or other licensed medical professional for the treatment of a medical (including mental) condition.

- **Minor** (as opposed to **Major**)**:** Illnesses that are cured with a single or limited number of medications or treatment and there are no ongoing complications. These illnesses do not extend to other organs if treated appropriately, and are managed by one or two visits to a physician. Examples include: conjunctivitis (pink eye), minor skin trauma such as lacerations (cuts), and pharyngitis (sore throat).

- **Operated** means you have had surgery performed by a licensed physician or other licensed medical professional.

- **Trauma:** Physical trauma is an injury to any tissue by physical or chemical means. This may include abrasions, lacerations, incisions, stab, puncture, or bullet wounds. When trauma occurs to the bone, this can result in fractures, dislocations, or sprains. Trauma can also be the result of exposure to toxic chemicals, high heat, irradiation, or electrical shock, as these can all cause damage to tissues and organs. Psychological trauma is the result of having an emotionally stressful situation occur that can be painful, distressing or shocking. These frequently result in lasting emotional, as well as physical, complications.

- **Treated** means you have received recommended medical care, or your medical (or mental) condition has been diagnosed and no treatment was recommended, or you are taking prescribed medications or being monitored for an illness or injury by or under the direction of a licensed physician or other licensed medical professional.

TURN PAGE TO CONTINUE ►

SECTION II. INSTRUCTIONS AND INFORMATION ABOUT YOU

TO FILL OUT THE QUESTIONNAIRE TAKE THE FOLLOWING STEPS:

1. Answer the questions to the best of your ability.
2. Make sure you **SIGN and DATE** this health questionnaire on the last page of this document.
3. In each section, answer the questions in the **bold boxes** first.
4. How you answer those questions will then inform you if you need to indicate a medical condition you may have (or had) in the **tables of conditions** that follow.
5. If you answered **NO** to the first bold question in each section, you can move on to the next section.
6. If you answered **YES** to having a certain medical condition, look at the detailed table of conditions to help you identify which specific condition(s) you may have or had.
7. Once you have looked at the conditions, **fill in the circle for the condition** you have or had.
8. Once you indicated having a specific condition, **move across the table** to answer questions related to the year you were diagnosed, if you had surgery for this condition (or surgery was recommended in the last 6 months), and when you were last operated on, treated, or medicated for that condition.
9. Mark all conditions you have or had. This includes any conditions which resulted from another primary diagnosis. For example, for cancers that have metastasized, mark all types of cancer for which you have been diagnosed, treated, and/or medicated.
10. If you have any **other medical condition(s)** not listed anywhere on the questionnaire, you will have the chance to write down this condition in Section (M) of the questionnaire.
11. If you are the **parent or guardian** who is filling out this questionnaire for a child or individual with disabilities, please answer the questions as if "you" means the child or disabled individual.

Do not say you have a condition unless a doctor or other licensed medical care provider told you that you have or had a condition. **Be sure to mark <u>all</u> of the conditions you have or had.**

ABOUT YOU – YOU MUST FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF:

First Name ____ M.I. ____ Last Name ____

Date of Birth __ / __ / ____

Contact Phone Number (___) ___ - ____

Height: Feet ___ Inches ___ Weight ___

Email Address ____

Gender

Are you male or female? ○ Male ○ Female

QUESTIONS? IF YOU HAVE QUESTIONS ABOUT THIS QUESTIONNAIRE – call the insurance carrier that you are submitting it to or your insurance agent.

A. Medical Conditions

Have you been diagnosed, treated and/or medicated for any of the following conditions within the last 10 years? Please answer yes or no below.	
Do not answer YES that you have or had a medical condition unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW. WHEN YOU HAVE COMPLETED THIS SECTION, YOU MAY CHOOSE TO ANSWER EACH SECTION (B) THROUGH (M), OR YOU MAY PROCEED TO SECTION (N).**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION AND COMPLETE SECTIONS (B) – (N).**

	A. Medical Conditions - List of conditions:	**Fill in which condition you have (or had)**	**If you filled in a condition, what year were you diagnosed?**
1	AIDS	○	
2	Amyotrophic lateral sclerosis - ALS - Lou Gehrig's Disease	○	
3	Autism - Severe: minimal and inappropriate interaction with others, repetitive or restrictive behaviors (hand flapping, head rolling, self injury), limited or no speech, frequently requiring placement into a special education setting	○	
4	Bilateral (left and right) leg amputation	○	
5	Biliary atresia (congenital blockage of bile duct)	○	
6	Blood & lymphatic system or lymph nodes – cancer, except leukemia (e.g., lymphoma, multiple myeloma)	○	
7	Brain degeneration (progressive loss of brain function)	○	
8	Brain injury resulting in a deep coma	○	
9	Central nervous system (brain or spinal cord) abnormal development prior to birth	○	
10	Cerebral Palsy (CP)	○	
11	Cervical (neck) Spina Bifida	○	
12	Cervical spinal (neck) fracture resulting in injury to the spinal cord	○	
13	Chronic or acute renal failure, with or without End Stage Renal Disease – ESRD	○	
14	Chronic pulmonary heart disease (e.g., right heart disease)	○	
15	Congenital hypothyroidism (cretinism)	○	
16	Coronary artery disease (heart disease) or a heart valve (mitral, aortic) disorder, **without heart attack, requiring surgery** including cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery	○	
17	Coronary artery disease (heart disease), **with heart attack, requiring surgery** including cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery, or with cardiac complications	○	

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	A. Medical Conditions - List of conditions:	Fill in which condition you have (or had)	If you filled in a condition, what year were you diagnosed?
18	Cystic fibrosis	○	
19	Down's Syndrome	○	
20	Encephalitis due to a bacterial or viral origin	○	
21	Fetal damage resulting from medication usage	○	
22	Fetal immaturity: less than 24 weeks or less than 1lb at birth and with problems if more than 5 years old	○	
23	Fragile X Syndrome	○	
24	Hemophilia	○	
25	HIV sero-positive, without AIDS	○	
26	Huntington's Chorea	○	
27	Intestinal perforation or rupture that resulted in peritonitis (abdominal infection), a colostomy and/or ileostomy, septicemia (infection of the blood), and/or septic shock	○	
28	Lymphoma (cancerous tumor of the lymph tissue or lymph nodes, e.g., Hodgkin's Disease) - advanced or having spread to involve multiple lymph nodes or other organs	○	
29	Mitral or aortic valve narrowing (stenosis) or insufficiency	○	
30	MRSA (staph) infection - severe or complicated	○	
31	Mucopolysaccharidoses (e.g., Hunter's Syndrome)	○	
32	Multiple myeloma	○	
33	Multiple Sclerosis (MS)	○	
34	Muscular Dystrophies (e.g., Duchenne (DMD), Becker (BMD), Emery-Dreifuss (EDMD), Limb-girdle (LGMD), Facioscapulohumeral (FSHD), Myotonic (MMD), Congenital (CMD), and Pompe Disease)	○	
35	Necrotizing fasciitis (flesh-eating bacterial infection)	○	
36	Nephrotic (kidney) Syndrome (nephrosis)	○	
37	Peritonitis (inflammation/infection of the abdominal lining)	○	
38	Psychotic or schizophrenic disorders	○	
39	Reticulosarcoma (e.g., Non-Hodgkin's Lymphoma)	○	
40	Rheumatic heart disease with complication (heart valve damage, anemia)	○	
41	Septicemia (blood infection) with health conditions resulting in complications, such as infection to other body parts	○	
42	Severe burns on more than 50% of one's body	○	
43	Spinal abscess (infected area)	○	

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	A. Medical Conditions - List of conditions:	Fill in which condition you have (or had)	If you filled in a condition, what year were you diagnosed?
44	Spinal cord injury affecting the lumbar region (L1-L5), sacral region (S1-S5), and/or the coccyx	○	
45	Subdural hematoma (blood clot on the brain) with complications (e.g., loss of speech, sight, memory; paralysis)	○	
46	Thoracic (middle back) spinal cord injury	○	
47	Transplants (other than cornea)	○	
48	Tuberculosis (TB) pulmonary (lung)	○	
49	Ulcerative colitis	○	
50	Wegener's Granulomatosis	○	

- **If you answered "YES" to Section (A), you may choose to answer each Section (B) through (M), or you may skip to Section (N).**
- **If you answered "NO" to Section (A), please continue to the next page and complete Sections (B) through (N).**

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B. Cancer or Benign Tumors

Cancer (malignancy) develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells. Normal body cells grow, divide, and die in an orderly fashion. Because cancer cells continue to grow and divide, they are different from normal cells. Sometimes these cells form tumors, which are abnormal growths of body tissues. Not all tumors are cancerous.

Have you been diagnosed, treated and/or medicated for cancer or a benign tumor in the last 10 years?	
Do not answer YES if you have or had cancer or a benign tumor unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CANCER(S) OR BENIGN TUMOR(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (C) ON CIRCULATORY, BLOOD OR HEART CONDITIONS.**

To fill out the table below follow these steps:

1. **First,** fill in the circle next to the **type** of cancer or tumor you have or had
2. **Second,** if you filled in the circle for a type of cancer or tumor, indicate the **year** of your diagnosis
3. **Third**, if you filled in the circle for a type of cancer or tumor, indicate if it was ever operated on **or if surgery has been recommended in the last 6 months**
4. **Fourth**, if you filled in the circle for a type of cancer or tumor, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

B. Cancer or Benign Tumor(s) What type of cancer(s) or tumor(s) do you or did you have in the last 10 years? **If you have or had cancer, mark all sites of the cancer, including secondary cancers (metastasis).** Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
51	Bone and connective tissue – benign tumor	○		○	○	○	○	○
52	Bone cancer	○		○	○	○	○	○
53	Breast - benign tumor	○		○	○	○	○	○
54	Breast cancer	○		○	○	○	○	○
55	Central nervous system (brain and spinal cord) – benign tumor	○		○	○	○	○	○
56	Central nervous system (brain and spinal cord) cancer	○		○	○	○	○	○
57	Ear/nose/throat - benign tumor (e.g., Cystic hygroma)	○		○	○	○	○	○
58	Ear/nose/throat cancer	○		○	○	○	○	○
59	Eye, external - benign tumor	○		○	○	○	○	○
60	Eye, external, cancer	○		○	○	○	○	○
61	Eye, internal - benign tumor	○		○	○	○	○	○
62	Eye, internal, cancer	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

	B. Cancer or Benign Tumor(s) What type of cancer(s) or tumor(s) do you or did you have in the last 10 years? **If you have or had cancer, mark all sites of the cancer, including secondary cancers (metastasis).** Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
63	Female genital tract (ovary, uterus, cervix, vagina) - benign tumor	○		○	○	○	○	○
64	Female genital tract (ovary, uterus, cervix, vagina) cancer	○		○	○	○	○	○
65	Genitourinary (testicular, kidney, ureter, urinary bladder, urethra) cancer, not including prostate	○		○	○	○	○	○
66	Hepatobiliary system (liver, gall bladder, bile duct) cancer	○		○	○	○	○	○
67	Intestine or abdominal cavity - benign tumor	○		○	○	○	○	○
68	Intestine or abdominal cavity cancer	○		○	○	○	○	○
69	Leukemia	○		○	○	○	○	○
70	Pancreatic gland cancer	○		○	○	○	○	○
71	Peripheral nerves (nerves other than the brain or spinal cord) - tumor (cancerous or benign)	○		○	○	○	○	○
72	Pituitary, adrenal, or parathyroid gland - benign tumor	○		○	○	○	○	○
73	Pituitary, adrenal, or parathyroid gland cancer	○		○	○	○	○	○
74	Prostate - benign tumor	○		○	○	○	○	○
75	Prostate cancer	○		○	○	○	○	○
76	Pulmonary system (lungs, bronchi, trachea) - benign tumor	○		○	○	○	○	○
77	Pulmonary system (lungs, bronchi, trachea) cancer	○		○	○	○	○	○
78	Rectum or anus - benign tumor	○		○	○	○	○	○
79	Rectum or anus cancer	○		○	○	○	○	○
80	Skin - benign abnormal growth	○		○	○	○	○	○
81	Skin cancer	○		○	○	○	○	○
82	Stomach or esophagus - benign tumor	○		○	○	○	○	○
83	Stomach or esophagus cancer	○		○	○	○	○	○
84	Thyroid gland cancer	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

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C. Circulatory, Blood or Heart Conditions

Our vascular system is made up of blood vessels, which are part of our circulatory or cardiovascular system that works with the beating heart. With each beat, the heart pumps blood into the vessels and throughout the body, providing nutrients and oxygen to cells. The circulating blood removes waste products, toxins and other harmful substances. Our circulatory system is critical to many body functions, especially our respiratory or lung function, digestion, waste removal and body temperature. Medical conditions can occur when these systems are not working properly.

Have you been diagnosed, treated and/or medicated for blood, circulatory or heart conditions in the last 10 years?	
Do not answer YES if you have or had a circulatory, blood or heart condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (D) ON DIGESTIVE CONDITIONS.**

To fill out the table below follow these steps:

1. **First,** fill in the circle next to the type of condition you have or had
2. **Second,** if you filled in the circle for a condition, write the year of your diagnosis
3. **Third,** if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

C. Circulatory, Blood or Heart Conditions What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
85	Aortic aneurysm (balloon-like weakened area)	○		○	○	○	○	○
86	Arterial aneurysm, except aorta	○		○	○	○	○	○
87	Arterial disease - major and noninflammatory (e.g., renal artery hyperplasia) or embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of artery	○		○	○	○	○	○
88	Arterial inflammation (e.g., vasculitis, arteritis)	○		○	○	○	○	○
89	Arterial trauma (physical injury to an artery)	○		○	○	○	○	○
90	Atherosclerosis (hardening of the arteries)	○		○	○	○	○	○
91	Blood – major non-cancerous diseases (e.g., thalassemia major, thrombocytopenia, purpura, but excluding hemophilia)	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

	C. Circulatory, Blood or Heart Conditions What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
92	Blood – minor non-cancerous diseases (e.g., thalassemia minor, polycythemia vera: excess red blood cells)	○		○	○	○	○	○
93	Cardiac (heart) infections (e.g., myocarditis or endocarditis)	○		○	○	○	○	○
94	Cardiac congenital (occurring at or before birth) disorders	○		○	○	○	○	○
95	Conduction disorders (abnormal heartbeat – fast, slow or irregular heart rhythm) e.g., bundle branch block, sick sinus syndrome	○		○	○	○	○	○
96	Congestive Heart Failure (CHF)	○		○	○	○	○	○
97	Coronary artery disease, with heart attack, **anterior wall, not requiring surgery** such as cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery	○		○	○	○	○	○
98	Coronary artery disease, with heart attack, **inferior wall, not requiring surgery** such as cardiac catheterization, angioplasty (balloon and/or stent), coronary artery bypass surgery (CABG), and/or heart valve surgery, and **without complications**	○		○	○	○	○	○
99	Embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of veins	○		○	○	○	○	○
100	Hepatitis (A, B, or C) – infectious	○		○	○	○	○	○
101	Hyperlipidemia – high cholesterol (if known, HDL/LDL is less than 0.3)	○		○	○	○	○	○
102	Hypertension – benign (high blood pressure with no signs of illness)	○		○	○	○	○	○
103	Hypertension – malignant (high blood pressure 200/140, with persistent headache, vision problems, and kidney problems)	○		○	○	○	○	○

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	C. Circulatory, Blood or Heart Conditions What type of circulatory, blood or heart condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
104	Ischemic heart disease, except Congestive Heart Failure (CHF) – (blocked heart arteries, either partial or complete without a heart attack)	○		○	○	○	○	○
105	Lipidoses – unable to process fats (e.g., Fabry's disease, Gaucher's disease, Krabbe's disease, Niemann-Pick disease, Refsum's disease, Tay-Sachs disease, Wolman's disease)	○		○	○	○	○	○
106	Lymphatic tissue disorders that are non-cancerous (e.g., Splenomegaly - enlarged spleen or lymphedema)	○		○	○	○	○	○
107	Phlebitis (vein inflammation) and thrombophlebitis (clot)	○		○	○	○	○	○
108	Pulmonary heart disease, without heart attack	○		○	○	○	○	○
109	Septicemia (blood infection) without complications	○		○	○	○	○	○
110	Sickle cell anemia	○		○	○	○	○	○
111	Valve disorder (aortic, mitral) with complications such as heart failure, enlarged heart, or irregular heartbeat	○		○	○	○	○	○
112	Valve disorder (aortic, mitral) without complications	○		○	○	○	○	○
113	Varicose veins of lower extremity	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

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D. Digestive Conditions

When you eat, your body breaks food down to a form it can use to build and nourish cells and provide energy. This process is called digestion. Your digestive system is a series of hollow organs joined in a long, twisting tube. It runs from your mouth to your anus and includes your esophagus, stomach, and small and large intestines. Your liver, gallbladder and pancreas are also involved. They produce juices to help digestion. There are many types of digestive disorders and conditions. The symptoms vary widely depending on the problem.

Have you been diagnosed, treated and/or medicated for digestive conditions in the last 10 years?	
Do not answer YES if you have or had a digestive condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (E) ON ENDOCRINE, LYMPHATIC, OR METABOLIC CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third,** if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

D. Digestive Conditions What type of digestive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
114	Bowel obstruction/blockage	○		○	○	○	○	○
115	Cirrhosis (liver)	○		○	○	○	○	○
116	Diverticulitis (inflammation/infection of the colon)	○		○	○	○	○	○
117	Esophagus – inflammation	○		○	○	○	○	○
118	Gastritis (inflammation/infection of the stomach) and/or duodenitis (small intestine)	○		○	○	○	○	○
119	Hepatobiliary system (liver, gall bladder, bile duct) - trauma (physical injury)	○		○	○	○	○	○
120	Hernia – hiatal	○		○	○	○	○	○
121	Intestine and abdomen problems due to birth and genetics (e.g., Meckel's diverticulum, congenital obstructions, occlusions)	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

D. Digestive Conditions What type of digestive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
122	Intestines & abdomen – inflammation (e.g., Inflammatory Bowel Disease (IBD), ileitis, colitis, Crohn's Disease)	○		○	○	○	○	○
123	Intestines & abdomen - trauma (physical injury)	○		○	○	○	○	○
124	Intestines & abdomen – vascular (blood vessel) disease (e.g., mesenteric infarction, intestinal ischemia)	○		○	○	○	○	○
125	Irritable Bowel Syndrome (IBS)	○		○	○	○	○	○
126	Pancreas - benign endocrine disorder (e.g., Zollinger-Ellison syndrome, pseudopapillary tumor of the pancreas, cystadenoma of the pancreas)	○		○	○	○	○	○
127	Pancreatitis (inflammation/infection of the pancreas), acute or short term	○		○	○	○	○	○
128	Pancreatitis (inflammation/infection of the pancreas), chronic or ongoing	○		○	○	○	○	○
129	Peptic (stomach) ulcer	○		○	○	○	○	○
130	Rectum or anus – infections (e.g., Human Papillomavirus (HPV) infection)	○		○	○	○	○	○
131	Rectum or anus – inflammation (e.g., hemorrhoids, proctitis)	○		○	○	○	○	○
132	Stomach or esophagus – trauma (physical injury) or anomaly (malformation, occlusion, obstruction), e.g., pyloric stenosis	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

E. Endocrine, Lymphatic or Metabolic Conditions

The foundations of the endocrine system are the hormones and glands. As the body's chemical messengers, hormones (pronounced: hor-moanz) transfer information and instructions from one set of cells to another. Too much or too little of any hormone can be harmful to your body. The lymphatic system clears away infection and keeps your body fluids in balance. Lymph vessels, which are different from blood vessels, carry fluid called lymph throughout your body. If it's not working properly, fluid builds in your tissues and causes swelling. Other lymphatic system problems can include infections, blockage, and cancer. Metabolism is the process your body uses to get or make energy from the food you eat. Chemicals in your digestive system break the food parts down into sugars and acids, your body's fuel. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process.

Have you been diagnosed, treated and/or medicated for an endocrine, lymphatic or metabolic condition(s) in the last 10 years?	
Do not answer YES if you have or had an endocrine, lymphatic or metabolic condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (F) ON MUSCLE, SKELETAL, OR SKIN CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

E. Endocrine, Lymphatic or Metabolic Conditions What type of endocrine, lymphatic or metabolic condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
133	Adrenal gland (Cushing's Disease, hyperaldosteronism) - hyper (over) production of adrenal hormones	○		○	○	○	○	○
134	Diabetes - Type I, with other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac)	○		○	○	○	○	○
135	Diabetes - Type I, without other health conditions	○		○	○	○	○	○
136	Diabetes - Type II, with other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac)	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

	E. Endocrine, Lymphatic or Metabolic Conditions What type of endocrine, lymphatic or metabolic condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
137	Diabetes - Type II, without other health conditions	○		○	○	○	○	○
138	Diabetic retinopathy (eye problems)	○		○	○	○	○	○
139	Goiter - non-toxic (enlarged thyroid that does not produce an excess of thyroid hormones)	○		○	○	○	○	○
140	Organic drug (illnesses caused by medications) or metabolic disorders (illnesses where the body cannot properly utilize proteins or carbohydrates)	○		○	○	○	○	○
141	Parathyroid gland - hypo (under) functioning	○		○	○	○	○	○
142	Thyroid gland - hyper (over) or hypo (under) functioning	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

F. Muscle, Skeletal or Skin Conditions

Musculoskeletal conditions comprise over one hundred diseases and syndromes, which are usually progressive and associated with pain and involve your muscles, joints and bones. The largest organ in the body, the skin, is the first line of defense against dirt, germs and other foreign objects. Most skin disorders display symptoms on the surface of the skin.

Have you been diagnosed, treated and/or medicated for a muscle, skeletal or skin condition(s) in the last 10 years?	
Do not answer YES if you have or had a muscle, skeletal or skin condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (G) ON NON-PSYCHIATRIC CONDITIONS OF THE NERVOUS SYSTEM.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

F. Muscle, Skeletal or Skin Conditions What type of muscle, skeletal or skin condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
143	Bone & joint – infections (e.g., osteomyelitis or septic arthritis)	○		○	○	○	○	○
144	Burns less than 50% of one's body	○		○	○	○	○	○
145	Bursitis (inflammation around the joint) & tendonitis (inflammation of the tendon not resulting in a loss of mobility or not resulting in a disability)	○		○	○	○	○	○
146	Joint - major inflammation resulting in a loss of mobility or resulting in a disability (e.g., aseptic necrosis, polyarthritis, crystal arthropathies)	○		○	○	○	○	○
147	Joint degeneration, localized in one area (e.g., osteoarthritis or spondylolithiasis)	○		○	○	○	○	○
148	Joint derangement, other (e.g., dislocation, ligament and cartilage tears, herniated disk)	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

	F. Muscle, Skeletal or Skin Conditions What type of muscle, skeletal or skin condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
149	Major trauma (physical injury) other than bone break or dislocation (e.g., puncture, loss of blood supply to the limb)	○		○	○	○	○	○
150	Orthopedic deformity (abnormal bone or joint structure) leading to poor growth for either (e.g., kyphosis, scoliosis)	○		○	○	○	○	○
151	Osteoporosis	○		○	○	○	○	○
152	Rheumatoid Arthritis (RA) – adult	○		○	○	○	○	○
153	Rheumatoid Arthritis (RA) – juvenile	○		○	○	○	○	○
154	Skin – major bacterial infections (e.g., cellulitis or hidradenitis suppurativa), not including MRSA or Necrotizing fasciitis	○		○	○	○	○	○
155	Skin & subcutaneous (under the skin) tissue – inflammation (e.g., psoriasis, cellulitis, fasciitis, pemphigus, dermatomyositis)	○		○	○	○	○	○
156	Spinal or back trauma (physical injury), including strains and sprains, that does not resolve within 3 months	○		○	○	○	○	○

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G. Non-Psychiatric Conditions of the Nervous System

The nervous system is a complex, sophisticated system that regulates and coordinates body activities. Disorders of the nervous system may involve the following: vascular disorders (such as stroke), infections (such as meningitis), structural disorders (such as brain or spinal cord injury), functional disorders (such as headache, epilepsy) and degeneration (such as Parkinson's disease, multiple sclerosis and Alzheimer's disease) are all examples of these disorders or conditions.

Have you been diagnosed, treated and/or medicated for a non-psychiatric condition(s) of the nervous system in the last 10 years?	
Do not answer YES if you have or had non-psychiatric (non-mental health) condition(s) of the nervous system unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (H) ON PSYCHIATRIC (MENTAL HEALTH) CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

G. Non-Psychiatric Conditions of the Nervous System What type of non-psychiatric condition(s) of the nervous system do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
157	Alzheimer's disease	○		○	○	○	○	○
158	Brain abscess (infectious area)	○		○	○	○	○	○
159	Central nervous system (brain and spinal cord) – diseases that are congenital, hereditary, genetic, or due to toxic substances or medications (e.g., spina bifida, meningomyelocele, hydrocephalus), not including Alzheimer's disease, ALS, Parkinson's disease, or MS	○		○	○	○	○	○
160	Central nervous system (brain and spinal cord) - infection or inflammation (e.g., encephalitis, myelitis, but excluding meningitis)	○		○	○	○	○	○
161	Cerebral Vascular Accident (CVA) - stroke, hemorrhagic	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

	G. Non-Psychiatric Conditions of the Nervous System What type of non-psychiatric condition(s) of the nervous system do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.		What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
162	Cerebral Vascular Accident (CVA) - stroke, ischemic (caused by a lack of blood to the brain most often due to a clot)	○		○	○	○	○	○
163	Cranial nerves (affecting the head, face, eyes, tongue and/or throat including speech) - traumatic (physical injury) disorders	○		○	○	○	○	○
164	Cranial nerves (affecting the head, face, eyes, tongue and/or throat including speech) - inflammation (e.g., herpetic lesions to the face and/or eye, Bell's Palsy, trigeminal nerve disorders, facial nerve disorders and acoustic nerve disorders)	○		○	○	○	○	○
165	Epilepsy (seizures)	○		○	○	○	○	○
166	Meningitis (inflammation/infection of the lining of the brain and spinal cord)	○		○	○	○	○	○
167	Migraine headache with pre-headache aura, dizziness, nausea, blurred vision lasting over 72 hours in adults, 48 hours in children	○		○	○	○	○	○
168	Migraine headache, common, i.e. without a pre-headache aura but may have vague pre-headache symptoms such as mood changes or fatigue	○		○	○	○	○	○
169	Non-cranial nerves, including carpal tunnel – inflammation (e.g., sciatica)	○		○	○	○	○	○
170	Parkinson's disease	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

H. Psychiatric (Mental Health) Conditions

Mental illness is any disease or condition affecting the brain that influences the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

Have you been diagnosed, treated and/or medicated for psychiatric (mental health) conditions in the last 10 years?	
Do not answer YES if you have or had a psychiatric (mental health) condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (I) ON REPRODUCTIVE CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth**, if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

H. Psychiatric (Mental Health) Conditions What type of psychiatric (mental health) condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
171	Alcohol dependence (chronic alcoholism), **with** a medical diagnosis of other organs being affected	○		○	○	○	○	○
172	Alcohol dependence (chronic alcoholism), **without** a medical diagnosis of other organs being affected	○		○	○	○	○	○
173	Alcohol intoxication (poisoning) - drunkenness due to binge drinking and requiring medical attention	○		○	○	○	○	○
174	Anxiety, personality, somatoform (i.e., an illness where a physician cannot find an organic cause), or attention deficit (without hyperactivity) disorders or phobias (irrational fears)	○		○	○	○	○	○
175	Attention Deficit with Hyperactivity Disorder (ADHD)	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

H. Psychiatric (Mental Health) Conditions What type of psychiatric (mental health) condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the Yes column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
176	Autism – mild (i.e., able to attend school with limited assistance) or child psychoses	○		○	○	○	○	○
177	Cocaine, amphetamine, opioid or barbiturate dependence	○		○	○	○	○	○
178	Eating disorders (e.g., anorexia, bulimia)	○		○	○	○	○	○
179	Mood disorders, bipolar, **with** psychosis	○		○	○	○	○	○
180	Mood disorders, bipolar, **without** psychosis	○		○	○	○	○	○
181	Mood disorders, depression, **with** psychosis	○		○	○	○	○	○
182	Mood disorders, depression, **without** psychosis	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

I. Reproductive Conditions

Humans have the potential to create offspring when an egg from a woman is fertilized by sperm from a man. Eggs (ova) are made in the ovaries, and sperm in the testicles. The ovaries and testicles (gonads) also make sex hormones. The female reproductive system is made up of the vagina, womb (uterus), fallopian tubes and ovaries. The male reproductive system is made up of the penis, the testicles, the epididymis, the vas deferens and the prostate gland. Problems with male and female sex organs result in pain, swelling, tissue build up, hormone fluctuations, sexual impotence, infertility, prostate problems and sexually transmitted infectious diseases.

Have you been diagnosed, treated and/or medicated for a reproductive condition(s) in the last 10 years?	
Do not answer YES if you have or had a reproductive condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (J) ON RESPIRATORY CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery was recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

I. Reproductive Conditions What type of reproductive condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
183	Conditions (illnesses) associated with a woman's menstrual period (e.g., painful, infrequent, light, or heavy periods)	○		○	○	○	○	○
184	Conditions (illnesses) that impact fertility or problems with the female reproductive system, not including menopause	○		○	○	○	○	○
185	Disorders (problems) with the male reproductive system (e.g., conditions that result in low sperm count, genetic disorders such as Klinefelter's syndrome, varicocele)	○		○	○	○	○	○
186	Inflammation of female genital tract (ovary, uterus, cervix, vagina)	○		○	○	○	○	○
187	Vaginal infections (e.g., repetitive monilial (yeast) infections at least 3 times per year, or bacterial vaginitis, not related to sexual contact)	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

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J. Respiratory Conditions

The respiratory system consists of the airways, the lungs, and the respiratory muscles that control the movement of air in and out of the body. Within the lungs, molecules of oxygen and carbon dioxide are exchanged between the air we breathe and the blood. Respiratory disease includes problems that obstruct or restrict breathing and include breathing problems from infection, the environment or other diseases.

Have you been diagnosed, treated and/or medicated for a respiratory condition(s) in the last 10 years?	
Do not answer YES if you have or had a respiratory condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (K) ON URINARY CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

J. Respiratory Conditions What type of respiratory condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
188	Allergic rhinitis (nose irritation, hay fever)	○		○	○	○	○	○
189	Asthma	○		○	○	○	○	○
190	Chronic bronchitis resulting in cough and mucous production lasting at least 3 months	○		○	○	○	○	○
191	Chronic Pulmonary Disease (lungs, bronchi, trachea) occupational and environmental in origin (e.g., Black Lung disease, asbestosis, silicosis)	○		○	○	○	○	○
192	Emphysema (chronic obstructive pulmonary disease - COPD)	○		○	○	○	○	○
193	Lung infections (e.g., pneumonia, whooping cough) – bacterial	○		○	○	○	○	○
194	Lung infections (e.g., pneumonia, aspergillosis) – fungal or viral	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

J. Respiratory Conditions What type of respiratory condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
195	Pulmonary congenital anomalies - lung, bronchi, trachea (windpipe) problems that developed prior to birth (e.g., congenital bronchiectasis, congenital cystic lung, agenesis of the lung (lung does not form) and congenital problems of the diaphragm)	○		○	○	○	○	○
196	Tuberculosis (TB) - disseminated (infection spread to other body organs)	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

K. Urinary Conditions

The body takes nutrients from food and converts them to energy. After the body has taken the food that it needs, waste products are left behind in the bowel and in the blood. The urinary system keeps the chemicals and water in balance by removing a type of waste, called urea, from the blood. Urinary conditions are comprised of problems with how the kidneys, ureters, bladder, and urethra function.

Have you been diagnosed, treated and/or medicated for a urinary condition(s) in the last 10 years?	
Do not answer YES if you have or had a urinary condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (L) ON OTHER CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

K. Urinary Conditions What type of urinary condition(s) do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition **or** has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
197	Genitourinary system (kidney, ureter, urinary bladder, urethra, prostate) - trauma (physical injury)	○		○	○	○	○	○
198	Genitourinary system (ureter, urinary bladder, urethra, prostate), except kidney stones, not sexually transmitted, inflammation or infections	○		○	○	○	○	○
199	Kidney stones	○		○	○	○	○	○
200	Renal (kidney) inflammation – acute	○		○	○	○	○	○
201	Renal (kidney) inflammation – chronic	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

L. Other Conditions

Have you been diagnosed, treated and/or medicated for any of the following condition(s) in the last 10 years?	
Do not answer YES if you have or had any of these condition(s) unless a doctor or other licensed medical care provider told you that you have or had this condition.	
○ Yes	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW.**
○ No	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (M) FOR WRITE-IN CONDITIONS.**

To fill out the table below follow these steps:

1. **First**, fill in the circle next to the type of condition you have or had
2. **Second**, if you filled in the circle for a condition, write the year of your diagnosis
3. **Third**, if you filled in the circle for a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for this condition**
4. **Fourth,** if you filled in the circle for a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

L. Other Conditions What type of other condition(s) listed below do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
202	Autoimmune rheumatologic diseases (e.g., autoimmune connective diseases such as scleroderma, Sjogren's Syndrome, ankylosing spondylitis, or psoriatic arthritis), not including lupus or rheumatoid arthritis (RA)	○		○	○	○	○	○
203	Cataract	○		○	○	○	○	○
204	Chromosomal anomalies (e.g., Turner's Syndrome, Patau's Syndrome, Cri du Chat Syndrome, Velo-Cranio-Facial Syndrome (VCFS) and Prader-Willi Syndrome), not including Down's Syndrome or Fragile X Syndrome	○		○	○	○	○	○
205	Chronic sinusitis	○		○	○	○	○	○
206	Eye - external infections, except pink eye	○		○	○	○	○	○
207	Eye – internal infections	○		○	○	○	○	○
208	Eye problems developed prior to birth, including cataracts, ptosis or drooping eye, congenital blindness that occurred prior to birth	○		○	○	○	○	○
209	Glaucoma	○		○	○	○	○	○

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L. Other Conditions What type of other condition(s) listed below do you or did you have in the last 10 years? Fill in the condition(s) in the YES column.			What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
		Yes	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
210	Hearing disorders (decreased hearing, deafness), requiring treatment by a physician	○		○	○	○	○	○
211	Lupus with additional health problems including renal insufficiency or failure, memory or behavioral problems, pleurisy, heart attack, increased occurrence of infection, bone and tissue problems	○		○	○	○	○	○
212	Lupus, without complication	○		○	○	○	○	○
213	Macular (eye) degeneration	○		○	○	○	○	○
214	Major infectious diseases (e.g., malaria, Anthrax, leprosy, West Nile virus, herpes zoster, meningococcemia), not including HIV, septicemia, or tuberculosis	○		○	○	○	○	○
215	Mental retardation	○		○	○	○	○	○
216	Morbid obesity or Body Mass Index (BMI) over 40, if known	○		○	○	○	○	○
217	Sexually transmitted diseases, localized or systemic (e.g., syphilis, gonorrhea, chlamydia, herpes, genital warts), not including HIV-AIDS	○		○	○	○	○	○
218	Visual disturbances – major (blindness, detached retina, retinitis pigmentosa)	○		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

M. Write-in Conditions

Have you been diagnosed, treated and/or medicated for other medical conditions in the last 10 years not listed in any other tables above?	
Do not answer YES if you have or had other conditions unless a doctor or other licensed medical care provider told you that you have or had this condition.	
Yes ○	**IF YES, PLEASE INDICATE WHICH CONDITION(S) IN THE TABLE PROVIDED BELOW. WRITE-IN CONDITIONS WILL BE SCORED IF THAT CONDITION IS INCLUDED IN THE CURRENT SCORING SYSTEM.**
No ○	**IF NO, PLEASE CONTINUE TO THE NEXT SECTION (N) ON HEALTH BEHAVIORS.**

To fill out the table below follow these steps:

1. **First**, write in the type of condition you have or had in the first column of the table
2. **Second**, if you wrote in a condition, write the year of your diagnosis in the next column
3. **Third**, if you wrote in a condition, indicate if you were ever operated on **or if surgery has been recommended in the last 6 months for that condition**
4. **Fourth,** if you wrote in a condition, indicate when it was last operated on, treated, or medicated: less than one year ago, 1-3 years ago, or 4-10 years ago

M. Write-In Conditions What type of other condition(s) do you or did you have in the last 10 years? Write in the condition(s) below.	What year was this condition diagnosed?	Were you ever operated on for this condition or has surgery been recommended in the last 6 months?		When was this condition **most recently** operated on, treated or medicated?		
	Year	Yes	No	Less than one year ago	1 to 3 years ago	4 to 10 years ago
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○
		○	○	○	○	○

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

N. Health Behavior Questions

Please answer the following four questions. Your responses to these questions will not affect your score.

<table>
<tr>
<td>1. What is your current smoking status?
○ Current smoker
○ Former smoker
○ I have never smoked</td>
<td>2. During the past four weeks, how much bodily pain have you had?
○ No pain
○ Very mild pain
○ Mild pain
○ Moderate pain
○ Severe pain</td>
</tr>
<tr>
<td>3. How confident are you that you can control and manage most of your health problems?
○ Very confident
○ Somewhat confident
○ Not very confident
○ I do not have any health problems</td>
<td>4. During the past 4 weeks, how much have you been bothered by emotional problems such as feeling anxious, depressed, irritable, sad or downhearted and blue?
○ Not at all
○ Slightly
○ Moderately
○ Quite a bit
○ Extremely</td>
</tr>
</table>

WHEN YOU ARE DONE WITH THESE QUESTIONS PROCEED TO THE NEXT PAGE

SECTION III. SIGNATURE PAGE AND SCORES

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following:**

1. **All of the information I have given is true and complete**.
2. I understand that if I leave an answer blank to an individual condition it is the same as a "no" answer.
3. If I answered "no" to subsection (A), I have completed all remaining subsections, (B) through (N) of Section II, and indicated "yes" or "no" at the top of each subsection, (B) through (M).
4. I understand that if I omit or give false information I may lose my coverage, in which case I may have to pay for services paid under that coverage.
5. **I understand that if I intentionally give false information, in addition to losing my coverage, I may incur additional legal liability.**

IF YOU DO NOT SIGN AND DATE THIS QUESTIONNAIRE BELOW, IT WILL BE RETURNED TO YOU AND YOUR APPLICATION PROCESS WILL BE DELAYED.

Please print name, then sign and date in the space provided.

First Name | M.I. | Last Name

Signature

Date Signed __ / __ / ____

If you are signing on behalf of an underage child, check: ☐ **Parent** ☐ **Legal Guardian**

THANK YOU FOR COMPLETING THE STANDARD HEALTH QUESTIONNAIRE.

This questionnaire is updated at least every 18 months. In an effort to continually improve the questionnaire, we have included a brief survey on our website. If you would like to **provide feedback** on your experience filling out this questionnaire, please go to the following web address **www.wship.org/SHQsurvey**. This brief survey is optional and has no effect on your score.

FOR INSURANCE CARRIER USE ONLY. DO NOT MARK THIS SECTION.

Name of carrier

Date Reviewed __ / __ / ____ | Reviewer ID | Member SSN (optional)

	Condition #	Score		Condition #	Score		Condition #	Score
1.			5.			9.		
2.			6.			10.		
3.			7.			11.		
4.			8.			12.		

Total Score

○ Applicant Accepted ○ Applicant Denied