Application Submission Instructions

Please complete the attached application and send to Health Plan One either via fax or mail:

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!

APPLICATION FOR INDIVIDUAL COVERAGE

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association.

PO Box 91053
1800 Ninth Avenue
Seattle, WA 98111-9153

MAIL APPLICATION TO:
PO Box 1107
1602 21st Ave. MS LC1NW
Lewiston, ID 83501

All answers must be complete and accurate. Omissions or incomplete answers will result in the return of your application and may cause delays. In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20th of the month are eligible for an effective date of the first of the following month.

SECTION 1. TYPE OF APPLICATION (Check all that apply.)

❒ New Application ❒ Transferring from Regence BlueShield Group or COBRA Coverage ❒ Transferring from another carrier
❒ Changing Coverage Type ❒ Transferring from another County or State Blue Shield Plan
❒ Adding Dependent(s). (Dependent(s) may be added only to your current plan/deductible option, skip to Section 3.)

SECTION 2. TYPE OF NEW COVERAGE (SELECT ONLY ONE PLAN.)

PREFERRED PLANS — Deductible Options:				
Catastrophic		**Comprehensive**	**HSA Catastrophic**	**HSA Comprehensive**
Regence Breakthru 50 ❒ $2,500 ❒ $5,000	**Regence NowSelect**SM ❒ $2,500 ❒ $5,000 ❒ $7,500 ❒ $10,000	**Regence Breakthru 70** ❒ $1,000 ❒ $3,000	**Regence HSA Healthplan** ❒ $2,500 Member/ $5,000 Family ❒ $3,500 Member/ $7,000 Family	**Regence HSA Healthplan Comprehensive** ❒ $1,500 Member/ $3,000 Family

SECTION 3. PAYMENT TYPE (Select one of the following payment options.)

❒ Monthly ❒ Quarterly ❒ Semiannually ❒ Annually ❒ Automatic Bank Withdrawal
Complete the enclosed Subscriber Agreement for Preauthorized Bill Payment (monthly only).

SECTION 4. MEMBER INFORMATION To be eligible to apply for our individual plans, you must reside in our service area for at least 30 days prior to submitting your application and continue to live in our service area for six months out of the year. Eligible dependents include your spouse and/or children under the age of 25. Proof of residence within the Regence BlueShield service area may be required. (See the Application Checklist on page 4 for acceptable forms of proof.) Please list subscriber, spouse, and eligible dependent children for whom you are requesting coverage. Please provide Social Security numbers for yourself and all dependents over one year of age. **PLEASE PRINT.** (Persons who are eligible for Medicare coverage are not eligible for coverage under individual contracts.)

Name			Social Security Number	Sex	Birth Date	Relationship to Subscriber	Personal Care Provider (PCP) (Selections only)	PCP Number (See Provider Directory) (Please check the box if you are a current patient of this PCP)
First	MI	Last						
					/ /	SUBSCRIBER		❒
					/ /			❒
					/ /			❒
					/ /			❒

Street Address	City	State	ZIP	County
Mailing Address	City	State	ZIP	Home Telephone Number
Billing Address (if different)	City	State	ZIP	E-mail Address (optional)
Name and Health Insurance Claim Number of anyone listed on this form that is covered by Medicare.				

REGENCE BLUESHIELD USE ONLY				
Date Application Substantially Complete	**COB**	**Effective Date**	**Package Number**	**Agent Number**

SECTION 5. EXCEPTIONS FOR THE STANDARD HEALTH QUESTIONNAIRE

Please read the full explanation of the exceptions listed on the Standard Health Questionnaire (SHQ). Do your circumstances match any of the exceptions described in the SHQ? If so, please complete this section.

Name of person(s) not required to complete the Standard Health Questionnaire: _____

Reason for exception (check one):

- ❒ **Relocation:** Change of your prior coverage service area in Washington state. *Include a copy of a utility bill in your name from the prior address and a letter of verification from your prior carrier verifying that because you have moved, you no longer reside in their service area and they cannot provide health insurance at your new location.*
- ❒ **Provider Cancellation:** Health provider left network. *Include a letter of verification from the provider or carrier.*
- ❒ **COBRA Exhaustion:** Exhaustion of COBRA continuation. *Include a letter from the COBRA Administrator verifying that you have exhausted your COBRA benefits.*
- ❒ **COBRA Termination:** Former employer has gone out of business while member was on COBRA coverage. *Include a letter of verification from the employer or carrier.*
- ❒ **Employer's Plan Not Subject to COBRA or Loss of Basic Health Plan (BHP) Coverage:** You have lost or are losing coverage under an employer's plan that was not subject to COBRA coverage or under the BHP and you had at least 24 months of continuous group or BHP coverage before such loss. *Include a letter of verification from the employer or BHP.*
- ❒ **Other: Any additional exception(s) as listed on the SHQ not detailed above.** ***Please provide brief explanation.***

_____

In addition to the exceptions listed above, the Standard Health Questionnaire is not required for the **subscriber's** natural newborn or newly adopted child if the Company receives the application for coverage within 60 days of birth or placement of adoption (to be effective from date of birth or placement of adoption if the subscriber has active coverage on the date of birth or placement of adoption). Are you adding a newborn or newly adopted child with this application?

❒ Yes (For adopted child, include documentation indicating date of placement.)

SECTION 6. OTHER COVERAGE INFORMATION

Are you or any dependents who are applying for coverage currently covered on any group, individual, or self-insured plan?

❒ Yes ❒ No

If Yes, do you intend to replace your current plan with this contract? ❒ Yes ❒ No

Regence BlueShield Individual Plans contain a nine-month preexisting condition waiting period. In certain circumstances, we will waive or credit this waiting period based on current or prior coverage. To help us determine if you qualify for crediting the preexisting condition waiting period, please provide the following information, and attach a copy of your Certificate of Coverage from your current or prior carrier or a similar document showing the beginning and ending dates of your current coverage, if applicable. Please note: If your prior coverage was with a Regence BlueShield group plan, it is not necessary to include a copy of your Certificate of Coverage. SEE THE APPLICATION CHECKLIST ON PAGE 4 FOR MORE INFORMATION.

Name (First, Last)	Birth Date	Insurance Company	Policy Number	Dates of Coverage		Type of Coverage
				Date Coverage Began	Date Coverage Ended (indicate Active if you are currently covered)	• Employer Group • Individual • Medicare • COBRA • High Risk Pool
1.						
2.						
3.						
4.						
5.						

Deductible amount: $ _____ per individual per year

Out-of-pocket (stoploss) amount: $ _____ per individual per year

Deductible amount: $ _____ per family per year

Out-of-pocket (stoploss) amount: $ _____ per family per year

SECTION 7. NON-SMOKER CERTIFICATION STATEMENT

Complete this section only if you or your spouse is applying for a non-smokers' discount.

I certify that I have not smoked cigarettes, cigars, pipes, or used chewing tobacco, smokeless tobacco or any other form of tobacco or illegal drug substance within the past 12 months. PLEASE NOTE: The Company reserves the right to cancel coverage and collect claims payments or other damages if false information is submitted or if you fail to notify us you are no longer eligible for the non-smoker discount.

Applicant's Signature	Date	Spouse's Signature (If applying)	Date

SECTION 8. RELEASE OF INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me or my dependents (persons who are eligible for benefits coverage and are listed on the application) for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- A clinic, hospital, long term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies; or
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

*For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available from our Web site (www.wa.regence.com) or by phone at 1-800-458-3523 or 1-206-464-3663.

SECTION 9. APPLICATION AGREEMENT

I hereby apply for myself and/or for any spouse/dependent(s) listed on this application for coverage under the individual Contract indicated on this form or currently in effect if adding dependent(s). Contracts are offered through Regence BlueShield (the Company), an independent licensee of the Blue Cross and Blue Shield Association. I understand I will have the right to examine and return the Contract (if new) within 10 days of its delivery to me. I certify that my listed dependents and I meet the eligibility requirements set forth in **Section 4. Member Information**.

I agree to pay in advance the appropriate rates for myself and listed dependents and authorize rate increases as the Company deems necessary.

I have read and understand the waiting period provisions of the plan for which I am applying. I understand that under certain circumstances the Company may impose a **nine-month waiting period** for preexisting conditions as defined in the Contract.

I understand that this application is not an offer of coverage from Regence BlueShield and that submission of this application does not guarantee I will receive coverage. **Please sign and date Section 10. Signature and Date**

SECTION 10. SIGNATURE AND DATE

I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form and the Standard Health Questionnaire (if applicable) is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by you for the purposes of defrauding Regence BlueShield may result in Regence BlueShield taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

APPLICANT SIGNATURE:* _____ **DATE:** _____

*If signature by a personal representative of the member/enrollee, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: ❒ Parent ❒ Legal Guardian† ❒ Holder of Power of Attorney†
(†Attach legal documentation if legal guardian or Holder of Power of Attorney)

APPLICANT SPOUSE SIGNATURE: _____ **DATE:** _____
(If applying)

Dependent Signature: _____ **Dependent Signature:** _____
(If age 18 or over) (If age 18 or over)

In most cases, approved applications postmarked or delivered to Regence BlueShield by the 20th day of the month will be considered effective on the first day of the following month.

To select a later effective date, please indicate here: _____ / 01 /_____ (no more than two months from date of application).

HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD?

Please check the box that best describes how you heard about Regence BlueShield.

❒ Regence Group Plan ❒ Web site ❒ Seminar ❒ Agent ❒ Radio
❒ Television ❒ Newspaper ❒ Direct mail ❒ Word of mouth
❒ Other: _____

APPLICATION CHECKLIST

To ensure timely processing of your application, please review this checklist.

✓ Proof of residency may be required with all new applications. A photocopy of one of the following may be requested as proof of residency:

A. Valid Washington state driver's license or identification card.
B. Current utility bill with name and address.

✓ Did you indicate the type of coverage you are selecting in **Section 2. Type of New Coverage**? (Not required when adding dependent(s) to current coverage.)

✓ If you chose automatic bank withdrawal in **Section 3. Payment Type**, did you complete the **Subscriber Agreement for Preauthorized Bill Payment** form enclosed? Please pay your paper billing until you are notified that your electronic funds transfer has been initiated. Processing can take up to 60 days. (Not required when adding dependent(s) to current coverage.)

✓ Have you completed the **Standard Health Questionnaire** for yourself and each dependent you want to cover, if required?

✓ If you or your dependents do not have to complete the Standard Health Questionnaire, did you include the required proof (see **Section 5. Exceptions for the Standard Health Questionnaire**)?

✓ Did you complete **Section 6. Other Coverage Information**? Please provide us with documentation of current or prior coverage showing beginning and ending dates of coverage for you and/or your dependent(s) unless the current or prior coverage was with Regence BlueShield. Examples of documentation of coverage could include a copy of your Certificate of Coverage from your current or prior carrier. If you do not have a Certificate of Coverage, you may provide other documentation in accordance with federal law.

✓ If you and/or your dependent spouse are non-smokers, did you read **Section 7. Non-Smoker Certification Statement** and sign, if applicable?

✓ Please read **Section 8. Release of Information** and **Section 9. Application Agreement**.

✓ Did you sign and date this application (including all family members age 18 and over) in **Section 10. Signature and Date**?

✓ If an agent is helping you complete these forms, he or she must complete the **Agent Information** section.

Do not send a rate payment with your application. You will receive a statement from us upon acceptance of your application.

AGENT INFORMATION

IF APPLICATION IS BEING MADE THROUGH AN AGENT, HE/SHE MUST PROVIDE THE INFORMATION BELOW.

NOTE: Agents who do not have a current appointment with Regence BlueShield are not authorized to enroll members.

Agent Name William C. Stapleton	Firm or Agency HEALTH PLAN ONE	
Agent Address 1000 Bridgeport Ave, 4th FL, Shelton, CT 06484		Agent Telephone Number 877-567-5267
I certify I have verified that all persons applying for coverage are eligible. I further certify, to the best of my knowledge, the information on this application and the Standard Health Questionnaire (if applicable) has been completed truthfully by the applicant(s). _____ Agent Signature _____ Date		
Agent's Washington State License Number 720223 / 720222	Expiration Date 8/29/09 / 3/6/2010	Regence BlueShield Agent Number H02756
Contact Person		

If you have an agent, that agent may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence BlueShield. Incentives may be based on any of several factors, including the products you buy, your agent's volume of business with Regence, and the other services your agent provides to you. These incentives may have an indirect impact on your rates. For more information, please contact your agent.

Regence BlueShield is an Independent Licensee
of the Blue Cross and Blue Shield Association

PO Box 21267 • 1800 Ninth Avenue
Seattle, WA 98111-3267 • 206 464-3804

ELECTRONIC FUNDS TRANSFER FORM

I hereby authorize Regence BlueShield to initiate funds transfers for the amount of monthly rate for contract coverage from my bank* account indicated below and authorize my bank to honor these transfers.

Subscriber Name _____ Phone # _____

Subscriber Address _____

Identification Number _____

Account Name _____
(Please print as it appears on your bank account)

Bank _____ Bank Account # _____

City _____ State _____

Branch _____ Branch Phone # _____

Account funds are to be transferred from: ❒ Checking ❒ Savings (Please check only one)

Transfer funds on the following day of each month: ❒ 15th ❒ 25th (Please check only one)

I understand that this agreement will remain in effect until Regence BlueShield has received written notice from me that it should be cancelled. This notice shall be given not less than five days before the next scheduled payment.

Payment will be deducted each month on the date selected above for the following month's rate. The deduction will also include any outstanding balance on my account.

I have the right to stop payment of a transfer from my bank account to Regence BlueShield. I must notify my bank at least three days before the scheduled payment date.

I agree to indemnify and hold harmless Regence BlueShield for any claims arising out of transfers or deductions from my account pursuant to this agreement.

I understand it may take two to three months to process this form through my bank.

Subscriber Signature _____ Date _____

Account Holder Signature _____ Date _____

MUST ENCLOSE A VOIDED CHECK WITH THIS AGREEMENT

* As used herein, the term "bank" includes all types of depository financial institutions.

Regence

Regence BlueShield is an Independent Licensee of the Blue Cross and Blue Shield Association

Electronic Funds Transfer Payment Option

An automatic payment plan for Regence BlueShield Individual and Medicare Supplement members

We encourage you to consider enrolling in our Electronic Funds Transfer (EFT) payment plan. Your monthly rate payment will be electronically transferred from your bank account to Regence BlueShield, saving you both time and money. There is no trip to the post office and no check to write. EFT also saves you the expense of envelopes and stamps.

It's a simple way to pay your monthly plan rate by having it deducted from your bank account and paid directly to Regence BlueShield. Because your rate is automatically withdrawn, EFT ensures timely payments, preventing a possible lapse in coverage. And, your payments are taken care of even if you're out of town.

It's easy to enroll on our EFT payment plan.

To have your Regence BlueShield monthly rate paid through our EFT option, just complete, sign, and return the EFT authorization form located on the reverse side of this sheet. Be sure to include a voided check from the account you wish to make payment from. A return envelope is enclosed for your convenience. Once your EFT form is processed by Regence BlueShield, your payments will be deducted from your account.

Our EFT payment plan makes life just a little simpler for you.

EFT payment option is offered as a convenience for all Regence BlueShield Individual and Medicare Supplement enrollees. If you would like more information about our EFT payment option, call 1-888-344-8234.

Note: It may take two to three months to process the EFT information through your bank. Until then, please continue to submit your monthly rate payment directly to Regence BlueShield.

To sign up for the Regence BlueShield EFT payment plan today, simply complete and return the form on the reverse side of this sheet.

Electronic Funds Transfer Form located on reverse side.

Dear Member

This letter is in response to your recent inquiry about a non-smoking discount. A special discount off our regular rates is available to you or your spouse if you have not smoked or used tobacco products within the past 12 months.

To receive this discount, please fill out and sign the form at the bottom of the page. If we receive it by the 10th of the month, your discounted rates will be effective on your next regular billing.

Sincerely,

Member Services

- -

NON-SMOKER CERTIFICATION STATEMENT

I CERTIFY THAT I HAVE NOT SMOKED CIGARETTES, CIGARS, PIPES, OR USED CHEWING TOBACCO, SMOKELESS TOBACCO OR ANY OTHER FORM OF TOBACCO OR RELATED DRUG SUBSTANCE WITHIN THE PAST 12 MONTHS.

_____ _____

Name of Subscriber Name of Spouse

_____ _____

Identification Number Identification Number

_____

Home Phone

X_____ _____

Signature Date Signature Date

*Please Note: Regence BlueShield reserves the right to cancel coverage and collect claims payments or other damages, if false information is submitted or if you fail to notify us that you are no longer eligible.

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.*

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

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 <u>not</u> to WSHIP.**

TURN PAGE TO CONTINUE ►

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.

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.

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	○	

TABLE CONTINUED ON NEXT PAGE

	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)	○	

TABLE CONTINUED ON NEXT PAGE

	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).**

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

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)	○		○	○	○	○	○

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
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

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	○		○	○	○	○	○

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

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

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	○		○	○	○	○	○

TABLE CONTINUED ON NEXT PAGE

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.

1. What is your current **smoking** status? ○ Current smoker ○ Former smoker ○ I have never smoked	2. During the past four weeks, how much **bodily pain** have you had? ○ No pain ○ Very mild pain ○ Mild pain ○ Moderate pain ○ Severe pain
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	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

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