

Protected Health Information (PHI) Disclosure for Underwriting Only

Name: _____ Age: _____ Height: _____ Weight: _____ Work Phone: _____

Check all conditions, diseases, and treatments listed below for which you or any of your dependents have, or have been diagnosed, treated or counseled in the past 5 years. Explain any "Yes" answers in the detail selection below.

1 CANCER / TUMOR

- Yes No
- Lung Cancer
 - Breast Cancer
 - Liver Cancer
 - Colon Cancer
 - Hodgkin's /Leukemia/Lymphoma
 - Melanoma
 - Chemotherapy/Radiation Therapy
 - Other Cancer

2 HEART/CIRCULATORY/BLOOD

- Yes No
- Hemophilia
 - Stroke/Aneurysm
 - Angina
 - Bypass Surgery
 - Angioplasty / PTGA
 - Heart Attack
 - High Blood Pressure/Hypertension
 - Anemia
 - Heart Murmur/Mitral Valve Prolapsed
 - Skin Ulcer
 - Other Heart or Circulatory Disorder(s)

3 REPRODUCTIVE

- Yes No
- Anyone currently pregnant?
 - Infertility
 - Endometriosis
 - History of Pregnancy Complication
 - History of Premature Birth
 - Sexually Transmitted Disease(s)
 - Other Reproductive System Disorder(s)

4 INTESTINAL/ENDOCRINE

- Yes No
- Cirrhosis of the Liver
 - Hepatitis B
 - Hepatitis C
 - Crohn's Disease
 - Ulcerative Colitis
 - Adult/Juvenile Diabetes
 - Chronic Pancreases
 - Diverticulitis / Polyps
 - Hiatal Hernia/Reflux
 - Other Intestinal / Endocrine Disorder

5 BRAIN/NERVOUS

- Yes No
- Multiple Sclerosis
 - Paralysis
 - Cerebral Parlay
 - Muscular Dystrophy
 - Epilepsy
 - Migraines
 - Other Brain/Nervous System Disorder

6 IMMUNE SYSTEM

- Yes No
- AIDS/HIV + Infection
 - Enlarged Lymph Nodes
 - Systemic Lupus Erytematous
 - Other Immune System Disorder

7 LUNG/RESPIRATORY

- Yes No
- Cystic Fibrosis
 - Emphysema/Chronic Bronchitis
 - Sleep Apnea
 - Pneumonia
 - Asthma/Allergies
 - Other Lung or Respiratory Disorder

8 EYES/EARS/NOSE/THROAT

- Yes No
- Retinopathy
 - Cleft Lip/Palate
 - Chronic Sinusitis/Deviated Septum
 - Chronic Tonsillitis / Adenoiditis
 - Acoustic Neuroma
 - TMJ
 - Glaucoma/Cataracts
 - Chronic Ear Infections
 - Eye Glasses / Contact Lenses
 - Other/Eye/Ear/Nose/Throat Disorder

9 URINARY/KIDNEY

- Yes No
- Renal Failure / Dialysis
 - Polycystic Kidney Disease
 - Neurogenic Bladder
 - Kidney Stones
 - Chronic Prostatitis/Enlarged Prostate
 - Other Urinary/Kidney Disorder

10 BONE/SKELETAL/MUSCLE

- Yes No
- Pituitary Dwarfism / Growth Hormones
 - Spina Bifida
 - Bulging Disc / Herniated Disc
 - Rheumatoid Arthritis
 - Abdominal / Inguinal Hernia
 - Knee Injury or Impairment
 - Osteoarthritis
 - Pulled Back Muscle / Back Strain
 - Other Bone/Skeletal/Muscle Disorder

11 MENTAL/CHEMICAL DEPENDENCY

- Yes No
- Bipolar Disorder/Manic Depressive
 - Anorexia/Bulimia
 - Anxiety/Depression
 - Alcoholism
 - Drug Abuse
 - Attempted Suicide
 - Counseling
 - ADD/ADHD
 - Other Mental Health Disorder

12 TRANSPLANTS

- Yes No
- Organ Transplant
 - Bone Marrow Transplant
 - Discussed Possible Transplant

13 MEDICATIONS (List Name & Dosage below)

- Yes No
- Anyone currently taking medications?
 - Anyone taking medications in the last 12 months but not longer?

14 OTHER

- Yes No
- Advised to have surgery not yet done?
 - Unexplained weight changes in the last year?
 - Physical Exam with Abnormal Results?
 - Worker's Compensation Injury?
 - Short or Long Term Disability?
 - Had inpatient or outpatient surgery?
 - Used tobacco products in the last year?
 - Have you or your dependents had , or been treated for other illness not listed?

Please Explain each "Yes" answer to any condition (s) checked in the preceding boxes. IF you need additional space for your responses, please attach a separate sheet of paper.

Question #	Self / Spouse / Child	Diagnosis, Treatment or Reason for Physical Checkup	Date of Treatment, length of hospital stay	Current Status

PLEASE RETURN THIS FORM IN THE SEALED ENVELOPE PROVIDED. YOUR INFORMATION WILL BE KEPT CONFIDENTIAL TO THE EXTENT PERMITTED BY LAW.

Under HIPPA Privacy Regulations, 45 C.F.R. Subsection 164.514 (g), agents / brokers of a health plan are permitted to receive protected health information (PHI) for the purpose of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of a contract of health insurance. PHI will be disclosed to health plan insurers for this purpose.