BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

Small Group Health Questionnaire

GROUP NAME _____

(To be completed by Eligible Employees of groups with 2 - 25 participating employees)

REFERENCE #	Last Name	First Name	MI	Social Security #	Date of Birth	Gender Male	Gender Female	Height Feet/Inches	Weight Pounds	Used Tobacco products within past 12 months? Yes	Used Tobacco products within past 12 months? No
[1] Employee											
[2] Spouse											
[3] Dependent											
[4] Dependent											
[5] Dependent											

Employee Home Zip Code _____

PART A

Has anyone enrolling for coverage been diagnosed, treated, or had treatment recommended for any of the medical conditions listed below within the last 5 years unless otherwise indicated?

ANSWER ALL QUESTIONS - COMPLETE A DIAGNOSIS DETAIL FORM FOR ANY "YES" IN PART A

Yes	No	Condition
		1. Cancer - Melanoma or Breast Cancer within the past **10 years** or any other type of cancer within the past **5 years** including Leukemia, Lymphoma, Hodgkin's, or Malignant Cysts
		2. Heart / Circulatory - Heart Attack, Congestive Heart Failure, Angioplasty, Stroke, Aneurysm, Angina, or Serious Heart Disorder
		3. Blood - Hemophilia, Von Willebrand Disease, Sickle Cell Anemia, or other serious condition of the blood
		4. Reproductive Systems / Congenital - Cervical Dysplasia, Sexually Transmitted Disease, High Risk Maternity (Currently Pregnant **<17 or >41** Years of Age, Gestational Diabetic, Toxemia, Requiring Hospitalization, or Multiple Fetus), Premature Infant born within the last **24 months**, Congenital Disease or Birth Defect requiring ongoing treatment
		5. Diabetes - taking Insulin or more than one Medication or with either High Blood Pressure, Eye Disorder, Neuropathy (Numbness, Tingling or Pain to Hands or Feet), Kidney or Heart Disorde
		6. Intestinal / Endocrine - Ulcerative Colitis / Proctitus, Crohn's Disease, Chronic Pancreatitis, Cirrhosis of the Liver, Hepatitis (B, C, or E)
		7. Brain / Neurological - Alzheimer's, Cerebral Palsy, Epilepsy, Multiple Sclerosis, Muscular Dystrophy, Paralysis, Parkinson's Disease, Seizures, Lou Gehrig Disease or other serious related disorde
		8. Lung / Respiratory - Cystic Fibrosis, Emphysema, Tuberculosis, Sleep Apnea, RSV, Hospitalized for Asthma, Bronchitis, or Pneumonia, or other severe lung / respiratory condition
		9. Urinary / Kidney - (excluding Kidney Stones), Renal Failure / Dialysis, an Ostomy, or other Serious Urinary / Kidney Disorde
		10. Immune System - HIV Positive, AIDS, Discoid or Systemic Lupus, Connective Tissue Disorder, or other Immune System disorder within Lifetime
		11. Skeletal / Muscle / Skin - Rheumatoid Arthritis, Sciatica, or Arthritis requiring walker/wheelchair, surgery, or prosthesis, Severe Burn, Bulging/Herniated Disc, or other Serious Related Disorde
		12. Behavioral Health - Alcohol or Drug Abuse Treatment, Hospitalization or Outpatient Therapy for a Nervous & Mental or Eating Disorder
		13. Transplants - Organ or Bone Marrow Transplant (or awaiting or discussed such transplant) within **Lifetime**
		14. Within the last 12 months has any applicant: Been advised to have surgery, testing, or special immunizations but not yet done? Been hospitalized or had claims more than **$25,000** for any condition not listed on this application? Taken or been prescribed **3 or more** different medications for any one/single condition? Been on Disability from work more than two weeks?

PART B

Use the reference number (top left of page) associated with the person listed for each "Yes" answer when completing condition details below.

Yes	No	
		Has anyone enrolling for coverage seen a Physician within the past 12 months? List details below.
		Does anyone enrolling for coverage have any of the following conditions? Circle each one that applies and list details below.

a. Currently Pregnant **b.** Tumors **c.** Back Disorder **d.** Infertility **e.** Arthritis **f.** Gout **g.** Cysts **h.** Fibroids **i.** Menstrual Disorder **j.** Endometriosis **k.** Anemia **l.** Goiter

Ref. #	First Name	Condition	Diagnosis including Treatment, Prescription Drugs, or Reason for Visit	Date of Initial Diagnosis	Date of Last Treatment	Complete? Yes	Complete? No
1	Example-Employee Name	a.	Example - currently 6 months pregnant, no problems, see doctor twice a month, prenatal vitamins	11/1/2006	3/30/2007		X

PART C

For everyone enrolling, list all medications, other than those disclosed in Part B, currently taking or taken within the last 12 months. Please include the reason for taking and frequency of use.

Ref. #	First Name	Medications, Reason for Taking, and Frequency of Use
2	Example-Spouse Name	Example- Glucophage XR, diabetes, once a day / atenolol, hbp, once a day / Imitrex, migraines, as needed / Allegra OTC, allergies, as needed

Please Read Carefully and Sign Below: **It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.**

Employee Signature: _____ Date: _____