BlueCross BlueShield of Tennessee

An Independent Licensee of the BlueCross BlueShield Association

GROUP MEDICAL QUESTIONNAIRE

(For groups with more than 25 participating employees)

Company Name: _____

INSTRUCTIONS - COMPLETE ALL ITEMS - DO NOT LEAVE ANY BOX BLANK – IF NO OCCURRENCES, ENTER "0"

1. List the number of employees or dependents (including COBRA) either diagnosed, treated, or recommended treatment for the following conditions within the past 5 years or the specified time period

# Persons	Condition	# Persons	Condition
	HIV or Immune System Disorder		Renal Failure or Kidney Condition (excluding stones)
	Organ or Bone Marrow Transplant		Stroke or Cerebral Palsy
	Premature Infant (within the past 12 months)		Hemophilia or Sickle Cell Anemia
	Cancer*, Leukemia, or Hodgkin's Disease		Diabetes requiring Insulin or > 1 Medication
	Spinal Injuries Requiring Surgery or Rehab		Alcohol/Drug or Nervous/Mental requiring Inpatient or Outpatient Treatment
	Liver Condition		
	Heart Condition or Aneurysm		

***For Cancer do not include skin cancer unless it is a Melonoma or Sarcoma.**

2. (For conditions not listed in question #1 above) List conditions below concerning any person for which any of the following apply:

- **a. Incurred claims totaling more than $25,000 over the past 12 months**
- **b. Currently hospitalized or advised to have surgery/hospitalization within the next 6 months**
- **c. Either disabled or currently not actively employed due to a disability, illness, or injury**
- **d. Normal Maternity (currently pregnant)**
- **e. High Risk Maternity (currently pregnant under age 17 or over age 41, gestational diabetes, or toxemia)**

# 2 Item(s) (a,b,c,d,e)	Medical Condition
_____	1. _____
_____	2. _____
_____	3. _____
_____	4. _____
_____	5. _____

IMPORTANT - PLEASE READ CAREFULLY

This section to be completed by an approved company employee or owner with the best knowledge of the health conditions of employees and dependents of the Company/Employer.

The Company/Employer certifies that the information provided on this form is complete and accurate according to the knowledge of the Company / Employer. The Company/Employer shall notify the Insurer or agent promptly of any changes in this information that may affect the eligibility of employees of their dependents, including the addition of any newly eligible employees or dependents. The Company/Employer recognizes that misstatements may be cause for revocation of benefits or retroactive rate changes.

It is understood and agreed that insurance will be effective only on the date specified by the Insurer after the Insurer has approved the application.

Signature X _____ Date: _____

Title: _____ Company/Employer: _____

FOR THE AGENT ONLY:

The Agent representing this Company/Employer certifies that this information is complete and accurate according to the Agent's knowledge of the health conditions for this Company's employees and their dependents. If the Agent has any additional information, please attach an additional form with the conditions marked, and sign it. (This information is considered proprietary and will not be released to the Company/Employer if it varies from the Company's / Employer's information included above.)

Agent's Signature: _____ Date: _____