Regence

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

SHORT FORM HEALTH QUESTIONNAIRE AND MEDICAL HISTORY STATEMENT (Groups 51+)

MUST BE COMPLETED AND EXECUTED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS INCLUDING ANY WHO ARE DECLINING COVERAGE

Name of Employer's Group: ____________________ Group Number ☐☐☐☐☐☐☐☐

Section A

Name	Date of Birth	Sex	Enroll	Waive
Employee		☐ M ☐ F	☐	☐
Spouse		☐ M ☐ F	☐	☐
Children		☐ M ☐ F	☐	☐
		☐ M ☐ F	☐	☐
		☐ M ☐ F	☐	☐
		☐ M ☐ F	☐	☐
		☐ M ☐ F	☐	☐

Section B

1. Have you or any family member ever had, been told you had, consulted a health care professional for, or received counseling or treatment for: **(Check all that apply and explain below.)**
   a. conditions, disorders, diseases, or problems of or affecting the
   ☐ heart, ☐ immune system, ☐ kidney, ☐ liver, ☐ lungs, ☐ muscular system, ☐ nervous system ☐ pancreas
   b. ☐ alcohol or drug dependency, ☐ cancer, ☐ ulcerative colitis, ☐ congenital disorders, ☐ diabetes, ☐ leukemia
   ☐ lupus, ☐ severe mental illness, ☐ sexually transmitted disease/AIDS, ☐ stroke,
   c. ☐ any serious condition, ☐ disorder, ☐ disease or problem not listed above or are aware of such a condition existing?
2. Are you or any family member currently taking medications which exceed the cost of $500 per month? .... ☐ Yes ☐ No
3. Have you or any family member ever incurred medical expenses of $5,000 or more in any twelve-month period, or are such medical costs anticipated now or in the future? .... ☐ Yes ☐ No
4. Are you or any family member currently pregnant? (If yes, please explain below any anticipated problems and provide due date.)... ☐ Yes ☐ No

Section C

For any questions in Section B answered **Yes**, complete the following:

Question #	Employee or Family Member Name, Age, and Sex	List condition, disorder, disease, problem, treatment and degree of recovery	Dates of Care (Due Date if Pregnant)		Actual or Expected Cost of Care
			First	Last	

IF ADDITIONAL SPACE IS REQUIRED, USE REVERSE SIDE

I certify that the above information is true, correct and complete to the best of my knowledge, and I acknowledge that any coverage issued by the Plan will be issued in reliance thereon. Should any information provided by me in this questionnaire prove untrue, inaccurate, or incomplete, the Plan shall have the right to declare my contract null and void and to deny any claims incurred. I hereby authorize any health care provider to release to the Plan any medical records, documents or other medical information pertaining to my health or the health of my family members. I understand and agree that the Plan may require me to provide evidence of insurability at my own expense and that this and all other documents provided by me remain the exclusive property of the Plan.

Employee Signature ____________________ Date Signed ____________________