

RISK EVALUATION FORM

Section A:

 Group Name: _____
 Group Address: _____

 Date Completed: _____
 Effective Date Requested: _____
 Completed By: _____
 (Title): _____

Section B:

Has any employee or dependent:

Yes No

1. Had problems or been treated for any of the following? *(Circle all that apply and explain below.)*
 Alcoholism/Drug Addiction Arthritis, Birth Defects, Blood, Cancer, Diabetes, Digestive System
 Colitis, Heart, Infertility, Kidney/Urinary, Liver, Lung, Mental/Emotional, Nervous System/Muscular,
 Sexually Transmitted Disease/AIDS, or Stroke/Brain?
2. Experienced any other serious deformities, symptoms or problems not listed above or is aware of
 any such existing conditions?
3. Incurred medical expenses of \$5,000 or more, or is anticipating such medical costs
 now or in the future?
4. Been prevented by disability or other health condition from performing usual job activities on
 more than four occasions or for a total of more than two weeks?
5. Received or anticipate receiving any kind of transplant?

Section C:

 For any item in **Section B** checked "Yes", complete the following:

List Item#	List Applicant's Dependent's Name, Age and Sex	List Problem, Treatment and Degree of Recovery	Dates of Care First / Last	Cost of Care
			/	
			/	
			/	
			/	
			/	
			/	

Section D:

List any Applicant or Dependent who is currently pregnant:

List Applicant's or Dependent's Name (First, Last)	List Any Known or Anticipated Abnormalities (i.e., Twins, Premature Birth, C-Section, Etc.)	List Age	List Due Date (MM / YY)

IF ADDITIONAL SPACE IS REQUIRED, USE REVERSE SIDE:

I/We certify to the best of my/our knowledge that the above information is true, complete and accurate, and acknowledge that Regence BlueCross BlueShield of Utah, an independent licensee of the BlueCross and BlueShield Association, will issue coverage in reliance thereon.

 Signature (Group Official) Date Signature (Agent./Agency) Date