

# Pre-Screen Assessment



**Use this Pre-screen Assessment form to determine the eligibility of the applicant, spouse and any dependents. A Build Table, Ineligible Occupation List and Ineligible Medical Conditions List are provided on this form to help you answer the questions. You do not need to send this form in.**

Applicant Name \_\_\_\_\_ Date \_\_\_\_\_

1. Does the person to be insured have or ever had any of the ineligible medical conditions listed on the back of this form? Yes  No
2. Is the person to be insured over the acceptable height/weight ratio? Yes  No
3. Is the person to be insured employed in an ineligible occupation? Yes  No
4. Is the person to be insured currently pregnant? Yes  No   
(If yes, neither parent is eligible to apply for coverage until after the pregnancy has ended. The mother and child can be considered after postpartum and well-baby check-ups, usually 6 weeks later).
5. Is any person not to be insured, currently pregnant by any person to be insured? Yes  No   
(The father is eligible to apply for coverage after the pregnancy has ended).
6. Does the person to be insured have a pending doctor appointment or has diagnostic testing, treatment or surgery been recommended or scheduled that's not completed? Yes  No

If you answered "yes" to any of the questions, the applicant may not be eligible to continue the application process. You can continue the process with other applicants who have not answered "yes" to any questions above, but it is not a guarantee of coverage. You can proceed with Part 1 for those eligible applicants.

Please refer to your Underwriting and Administrative Guidelines for eligibility information about HIPAA and Basic and Standard Plans.

After completing Part 1, a review of the applicant's complete medical history will be performed during the Personal Health History Interview and is subject to underwriting rules and regulations. The applicant will need to provide detailed information regarding the medical history, including diagnosis of medical conditions, dates of treatment, and testing received (including date of full recovery, names and doses of medications, and names and addresses of medical practitioners).

Build Table – 16 years and over			Ineligible Occupation List
Height	Male-max for rating	Female-max for rating	
4'10"		185	Air Traffic Controllers
4'11"		190	Armed Forces personnel
5'0"	206	194	Asbestos/toxic chemical workers
5'1"	211	199	Divers (professional skin or scuba)
5'2"	215	203	Explosive workers
5'3"	220	208	Fishermen/Crew
5'4"	223	214	Government employees
5'5"	227	218	Off-shore oil workers
5'6"	232	223	Oil and natural gas workers, including off-shore operations
5'7"	238	229	Professional Auto Racers
5'8"	242	235	Rodeo Participants
5'9"	248	239	Professional athletes – Football, Wrestling, Baseball, Basketball
5'10"	253	244	Professional Crop Duster
5'11"	259	248	Persons temporarily unemployed, laid off or between jobs
6'0"	263	253	Structural Steel workers
6'1"	269		Stunt Flyers
6'2"	277		Underground miners
6'3"	283		
6'4"	290		
6'5"	298		

*Some state variations exist. See your Guidelines for more information.*



John Alden is a  
Fortis Health member company

# Ineligible Medical Conditions

## ADRENAL

Addison's disease  
Cushing's syndrome

## BLOOD

Aplastic anemia  
Aregenerative anemia  
Hemochromotosis  
Hemophilia A or B  
Hypoplastic anemia  
Idiopathic thrombocytopenia purpura (ITP)  
Leukemia  
Polycythemia vera  
Sickle cell anemia  
Thalassemia major  
Thrombocytopenia  
Von Willebrand's disease

## CANCER

Hodgkin's disease  
Lymphoblastoma  
Lymphoma  
Malignant Melanoma  
Rhabdomyosarcoma  
Sarcoma

## CARDIOVASCULAR

Arteritis  
Atherosclerosis thrombotic disease

## CIRCULATORY

Aneurysms  
Arterial embolism (clot)  
Arterial occlusion  
Arteriosclerosis obliterans (ASO)  
Arterivenous malformation  
Atherosclerosis obliterans  
Peripheral occlusive arterial disease (POAD)  
Stroke  
Takayasu's disease

## DIGESTIVE

Banti's syndrome (spleen)  
Crohn's disease  
Esophageal varices  
Gastric bypass/stapling  
Ischemic/ulcerative colitis  
Zollinger-Ellison syndrome (multiple tumors)

## ENDOCRINE

Diabetes Mellitus

## HEART/CARDIAC

Angina  
Aortic arch arteritis  
Aortic insufficiency

Aortic stenosis  
Aortitis  
Atrial fibrillation-chronic  
Atrial septal defect  
Cardiac decompensation  
Cardiomyopathy  
Coarctation of the aorta  
Congestive heart failure  
Cor pulmonale  
Coronary artery disease (CAD)  
Coronary heart disease (CHD)  
Heart attack  
Heart transplants  
Ischemic heart disease  
Kartagener's syndrome  
Mitral insufficiency  
Mitral stenosis  
Myocardial infarction (MI)  
Myocardial ischemia  
Pacemakers  
Premature ventricular contractions  
Tetralogy of fallot  
Tricuspid atresia  
Tricuspid insufficiency  
Tricuspid stenosis  
Ventricular arrhythmias  
Ventricular septal defect

## KIDNEY

Hydronephrosis  
Kidney injury (with dialysis)  
Kidney transplant  
Medullary sponge kidney  
Polycystic kidney

## LIVER

Cirrhosis  
Fatty liver  
Liver abscess (with residuals)  
Liver transplant

## LUNG/RESPIRATORY

Adult respiratory distress syndrome (ARDS)  
Bronchiectasis  
COPD  
Cystic Fibrosis  
Lung Transplants  
Pulmonic insufficiency  
Pulmonic stenosis  
Primary pulmonary hypertension

## NEUROLOGICAL

Alzheimer's disease  
Amyotrophic lateral sclerosis (ALS, Lou Gehrig's disease)  
Autism  
Cerebral palsy  
Gilles de la tourette's syndrome

Huntington's disease  
Hydrocephalus  
Mental retardation (severe)  
Multiple sclerosis  
Parkinson's disease  
Tourette's syndrome

## SKELTAL/MUSCLE - CONNECTIVE TISSUE

Amputees  
Ankylosing spondylitis  
Charcot's syndrome  
Eosinophilic granuloma of bone  
Hand-Schuller-Christian disease  
Hemiplegia  
Marfan's syndrome  
Muscular dystrophy  
Neurofibromatosis  
Paralysis  
Paraplegia  
Polio myelitis  
Polyarteritis  
Psoriatic arthritis  
Quadraplegia  
Rheumatoid arthritis  
Scleroderma  
Spina bifida  
Spinal curvature (with pulmonary, cardiac or spinal cord involvement)  
Systemic lupus erythematosus  
Wegener's granulomatosis

## SKIN

Ataxia telangiectasia

## SUBSTANCE/PSYCHIATRIC

Alcohol abuser  
Amphetamine, narcotic or psychedelic drug  
Anorexia nervosa  
Cocaine use  
Electroconvulsive therapy  
Marijuana use  
Suicide attempt

## URINARY

Bladder extrophy - symptomatic  
Hydronephrosis (bilateral or under age 20)  
Renal agenesis

## OTHER

AIDS

# Tele-App Part 1 Enrollment for Medical Insurance for Individuals and Families



## Agent Information

Agency Name \_\_\_\_\_ Agency Number \_\_\_\_\_  
 Agent Name \_\_\_\_\_ Agent Number \_\_\_\_\_  
 Agent Fax Number \_\_\_\_\_ Agent Phone Number \_\_\_\_\_  
 Agent E-mail Address \_\_\_\_\_ Sales Rep Number \_\_\_\_\_

## Person(s) To Be Insured

Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number
(Primary)						
1.						
(Spouse)						
2.						
3. Dependent Children						
Name	Last	First	M.I.	Sex	Date of Birth	Social Security Number

4. Resident Address (Street, City, State and ZIP code. No P.O. Boxes)  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 5. Home Phone Number \_\_\_\_\_ 6. E-Mail Address: \_\_\_\_\_

7. Are any of the proposed insureds covered by, or has application been made for, any type of medical insurance?  
 Yes (complete section below)  No

Proposed Insured's Name	Company Name	Company Phone Number	Group (G)/ Individual (I)	Type of Coverage	Effective Date	Term Date

8. Were all proposed insureds covered under the prior plan listed above?  Yes  No (If no, list those not covered)  
 9. Will this proposed coverage replace or change any existing health insurance? .....  Yes  No  
 10. Are any of the proposed insureds covered by Medicaid? .....  Yes  No  
 11. Will any proposed insured become eligible for any other form of medical insurance in the next six months? ..  Yes  No

## Billing

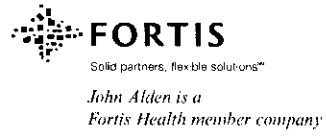
Check-O-Matic (Complete form on the next page)  Quarterly  Semi-Annual  Annual  
 Send premium notices to:  Insured or  Alternate Payor

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

I (we) hereby authorize John Alden Life Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account.

This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Payor Date Signed



Policies are issued and underwritten by John Alden Life Insurance Company, a Fortis Health member company, Milwaukee, WI.

## REMEMBER TO FAX PAGES 1 & 2 ONLY!

## Authorization for Check-O-Matic Billing

Choose the following option that applies:

**To begin Check-O-Matic withdrawals:**

Select a desired withdrawal day: (1-28): \_\_\_\_\_

Bank Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

**To add this policy to an existing Check-O-Matic:**

Existing COM Number \_\_\_\_\_

Associated Policy Number \_\_\_\_\_

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) 1234	Date _____
Pay to the order of	EXAMPLE	\$ _____
BANK NAME		Dollars
Memo		
*(Routing Number)	*(Account Number)	(Check Number)

\*Routing & Transit Numbers \_\_\_\_\_ \*Account Number \_\_\_\_\_

**Don't send in a voided check – just complete the routing and account information for Check-O-Matic!**

## Authorization To Obtain Medical Records and Attestation

In order to determine my (our) eligibility for insurance, I authorize any licensed physician, medical practitioner, hospital, clinic, any pharmacy, pharmacy benefit manager or pharmacy-related entity, any medically-related facility, insurance company, the Medical Information Bureau, employer, or consumer-reporting agency to give John Alden Life Insurance Company (or any consumer-reporting agency authorized by John Alden Life Insurance Company) any information regarding me or my family as to employment, other insurance coverage, personal information, and medical or pharmacy care, advice or treatment, or medication use.

**I represent to the best of my knowledge and belief, that all statements and answers on Part 1 are complete and true. My recorded personal health history, Part 1 and any amendments shall be the basis for the contract. I also agree that:**

**(1)** I must call John Alden Life Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto. **(2)** I understand that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, I have an obligation to contact John Alden Life Insurance Company and advise of such change. **(3)** Within 30 days of policy delivery, I must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning that signed acceptance to John Alden Life Insurance Company. **(4)** Except as otherwise provided in the Conditional Receipt, the insurance, if approved by John Alden Life Insurance Company, will be in force only when issued by John Alden Life Insurance Company and accepted by me. **(5)** I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my agent or broker. **(6)** If any of these conditions are not met, John Alden Life Insurance Company has the right to rescind its offer of coverage and the full extent of its liability shall be limited to the sum received.

Signature of Primary Proposed Insured

(Circle one)  
A.M. / P.M.

Signature of Spouse or Other Insured (if proposed to be insured)

Date Signed

Time Signed

City & State

Requested Policy Effective Date

Conditional Receipt Given?  Yes  No

## Health Advocates Alliance Membership Application

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for health insurance coverage. Membership privileges include the right to participate in all programs offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure, form 26588.

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association. If participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association-sponsored programs or benefits.

Member Name (Please print)

Member Signature

**REMEMBER TO FAX PAGES 1 & 2 ONLY!**

## Conditional Receipt

This Conditional Receipt is received from \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_ month \_\_\_\_\_ year.

The proposed insured has authorized either an electronic transfer of funds or money in the sum of \$\_\_\_\_\_ for the necessary amount of premium and/or any administrative processing fees, that will be paid in connection with completing a medical insurance enrollment form with John Alden Life Insurance Company.

No insurance will become effective prior to contract issue and acceptance by the proposed insured, except, insurance may become effective prior to the contract issue if and when each and every condition contained in this receipt is met. No agent or broker of the company is authorized to alter or waive any of the following conditions:

1. The proposed insured(s) must be, on the effective date, as hereinafter defined, a risk acceptable to the company under its rules, standards and practices for the exact contract and premium applied for, without any modification.
2. The amount of payment received with Part 1 or the actual withdrawal of funds by means of electronic transfer is an amount equal to the amount of the first full premium payment selected.
3. The proposed insured(s) must call John Alden Life Insurance Company and complete the telephone portion of the enrollment process within 10 days of commencement of the enrollment process and subsequently provide any and all medical information related thereto.
4. The contract is issued exactly as applied for within 30 days from the date of commencement of the enrollment process. If the contract is not issued within 30 days from the date of commencement of the enrollment process, there will be no coverage provided under the terms of this Conditional Receipt. Any coverage provided by the Conditional Receipt ends when the contract is delivered and accepted by you.
5. Proposed insured(s) completes all forms and provides all information required through the application and enrollment process.
6. Part 1 is submitted by an insurance agent or broker appropriately licensed to do business with the company and in the appropriate state jurisdiction.
7. Proposed insured(s) understands that if at any time through the enrollment process any of the previous information provided becomes inaccurate or is updated, he or she has an obligation to contact John Alden Life Insurance Company and advise of such change. Failure to do so may result in claim denial or rescission/revocation of coverage.
8. Within 30 days of policy issue, the proposed insured must formally accept the offer by verifying the accuracy of the enrollment form information with a signature and returning the signed acceptance to John Alden Life Insurance Company.

If each of the above conditions is fulfilled, then the insurance as provided by the terms and conditions of the contract applied for will become effective on the effective date prior to the contract delivery. "Effective Date" as used herein means the later of a) the date of commencement of the enrollment process, or b) the requested effective date. If one or more of the conditions are not met, John Alden Life Insurance Company may rescind its offer of coverage and its liability shall be limited to the return of the sum received.

\_\_\_\_\_  
Proposed Insured Signature

\_\_\_\_\_  
Agent Signature

Agent Name: \_\_\_\_\_  
Last First



Agent Phone Number: \_\_\_\_\_

## Personal Health History Interview Applicant Instructions

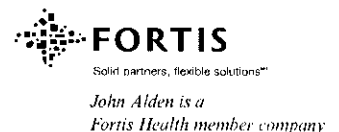
Thank you for your interest in our individual medical insurance. In addition to Part 1 that you completed with your agent, this Personal Health History Interview will help us determine eligibility for health insurance. One of our representatives will conduct your interview.

**Just follow these easy steps for a quick and accurate interview:**

- Choose one adult person who's applying for coverage to contact Fortis Health.
- Use this chart to provide information on all applicants:

APPLICANT(S)	CURRENT HEIGHT & WEIGHT	MEDICAL CONDITIONS IN PAST 10 YRS.	DATES WHEN MEDICAL CONDITIONS OCCURRED	PHYSICIAN NAMES AND ADDRESSES	TYPES OF TREATMENT & NAMES AND DOSES OF MEDICATIONS

- The caller will need to review the attached Medical Conditions list.** Please review all of the conditions and circle those that apply to each applicant. During your call, the representative will ask when the condition began, if it still exists and what type of treatment was provided.
- Call within 10 days of completing the enrollment form with your agent.** This allows the terms of your Conditional Receipt to be honored.



- Allow 20 minutes for the call.** Interview time may vary based on the number of proposed applicants and the extent of their medical conditions.
- Dial 800-596-0049** to reach a representative for your interview.
- Your agent will contact you** following the interview. Eligible applicants will be asked to attest to the interview information in writing.

***Thank you again for choosing us for your health insurance.  
Please keep this form for your records.***

Policies are issued and underwritten by John Alden Life Insurance Company, a Fortis Health member company, Milwaukee, Wisconsin.

### MEDICAL CONDITIONS LIST

*Please review the following medical conditions and circle any that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a physician for in the past 10 years. These conditions may be associated with the specific medical category under which they're listed. However, they are examples of the medical category and do not necessarily include all the conditions related to that category. Therefore, if you have a particular illness or condition which does not appear on the list or you are uncertain which category it's associated with, please tell your representative.*

#### **Lungs and Respiratory System**

Hayfever/allergies	Tuberculosis	Emphysema
Sinus infections	Pneumonia	Sleep Apnea
Asthma	Pneumothorax	Chronic Obstructive Pulmonary Disease
Bronchitis	Other _____	

#### **Ears/Eyes/Nose Disorders**

Ear infections	Meniere's	Deviated Septum
Ear tubes	Tinnitus	Cataracts
Hearing loss	Labyrinthitis	Glaucoma
Speech/hearing impairment	Tonsils/adenoids	Other _____

#### **Heart/Circulatory\***

High blood pressure	Heart murmur	Elevated Cholesterol
Heart attack	Mitral valve prolapse	Peripheral vascular disease
Chest pain	Phlebitis	Irregular heart beat
Varicose veins	Other _____	

\*Please provide the most current date and reading for blood pressure and cholesterol (including HDL, LDL and total cholesterol).

Blood pressure \_\_\_\_\_  
Cholesterol \_\_\_\_\_

#### **Diabetes/Thyroid**

Diabetes	Hypothyroid	Goiter
High blood sugar	Low blood sugar	Hypoglycemia
Hyperglycemia	Hyperthyroid	Other _____

#### **Blood/lymph/anemia**

Anemia (type)	Swollen lymph nodes	Lymphadenoopathy
Other _____		

**Cancer**

Provide location, type of cancer and any treatment received. If you do not know the specific diagnosis, contact your physician for that information.

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**Tumor/Cyst/Growth**

Tumor	Cyst	Polyp
Growth	Other _____	

**Breast**

Breast Implants	Fibrocystic breast disease	Other _____
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**Skin Disorders**

Acne	Rosacea	Psoriasis
Skin cancer	Eczema	Other _____

**Nervous System Disorders**

Unconsciousness	Vertigo	Epilepsy/seizures/convulsions
Paralysis	Multiple Sclerosis	Headaches/Migraines
Cerebral palsy	Bell's palsy	TIA (transient ischemic attack)/brain attack
Stroke/mini-stroke	Parkinson's disease	Other _____

**Mental/Nervous Disorders**

Emotional disorder	Anxiety	Depression
Anorexia	Bulimia	Attention Deficit Disorder
Schizophrenia	Panic Attacks	Obsessive Compulsive Disorder
Dysthymia	Insomnia	Oppositional Deviant Behavior
Other _____		

**Digestive Disorders**

Ulcer	Gastritis	Heartburn
Intestinal disorder	Colitis	Gallbladder
Crohn's	Ulcerative colitis	Irritable Bowel Syndrome
Hemorrhoids	Hernia	Pancreas disorder
Spleen disorder	Liver disorder	Hepatitis
GERD	Jaundice	Cirrhosis
Other _____		

**Bone/Muscle/Connective Tissue Disorders**

Arthritis	Gout	Carpal tunnel syndrome
Low back pain	Fractures	Lupus/Systemic lupus erythematosus (SLE)
ACL tear	Spinal fusion	Joint replacement
Back/spine disorder	Manipulation therapy	Muscular/Neuromuscular disorder
Osteoarthritis	Herniated disc	Degenerative joint disease
Scoliosis	Sprain/Strain	Bunions
Bursitis/Tendonitis	Chronic Fatigue Syndrome	Other _____

**Fixation /Prosthetic Device**

Plates	Screws	Pins
Implants	Breast implants	Shunts
Pacemaker	Valve replacement	Joint replacement

**Urinary System Disorders**

Kidney stones	Cystitis	Bladder infections
Prostatitis	Glomerulonephritis	Nephritis
Kidney disorder	Other _____	

**Reproductive System Disorders**

Penis	Testes	Vagina
Ovaries	Cervix	Uterus
Infertility	Irregular Menses	Uterine fibroids
Endometriosis	Ovarian cyst	Sexually transmitted diseases (STDs)
Rectocele	Cystocele	Prolapsed uterus
PMS	Polycystic ovarian disease	Benign Prostatic Hypertrophy
Other _____		

**Complications of Pregnancy**

Ectopic pregnancy	Miscarriage	Pre-eclampsia
Gestational diabetes	Pre-term labor	C-section
Other _____		

**Pap Smear**

Cervical dysplasia	Cervicitis	Atypical squamous cells (ASCUS)
Inflammation	Cervical cancer	Other _____

**Immune Deficiency**

Swollen lymph nodes	Loss of appetite	Weight loss
Chronic fatigue	Fever	Oral thrush
Skin rashes	Unexplained infections	Dementia
Depression	Pneumonia	Psychoneurotic disorders

**Congenital Disorders/Birth Defects/Developmental Disorders**

Down syndrome	Mental retardation	Autism
Cleft lip/palate	Club foot	Congenital heart defects
Speech therapy	Occupational therapy	Physical therapy
Other _____		

**Diagnostic Testing**

EKG (electrocardiogram)	Chest x-ray	Echocardiogram
Stress test	Angiogram	MRI
CT scan	Ultrasound	Mammogram
Colonoscopy	EGD (endoscopy)	Holter monitor
EEG	Bone density	Urinalysis
Blood test	Other _____	

**Hazardous activity**

Participation in any hazardous activity:		
Automobile racing	Motorcycle racing	Powerboat racing
Skydiving	Ultralight flying	Scuba diving
Hang gliding		

**Driving record**

Any adverse driving history:		
DUI (past 5 years)	Moving violations (past 2 years)	Speeding
Reckless driving		