

CONFIDENTIAL Health Insurance Pre-Qualification Form

Company Name _____

Employee _____ Date of Birth _____ M__ F__ Height _____ Weight _____ Smoker__ NS__

Spouse _____ Date of Birth _____ M__ F__ Height _____ Weight _____ Smoker__ NS__

Child _____ M__ F__ Date of Birth _____ Child _____ M__ F__ Date of Birth _____

Child _____ M__ F__ Date of Birth _____ Child _____ M__ F__ Date of Birth _____

The following questions apply to all family members:

1. Have you or any of your dependents had any medical condition and/or treatment in the past **10 years** requiring medical care on an in-patient or out-patient basis? Yes__ No__

Name	Date(s)	Condition	Treatment	Results

1. Have you or any of your dependents been prescribed medication in the past 24 months? Yes__ No__

Name	Type	Dosage	For What Reason(s)	Currently Taking? Y__ N__

3. Are you or any of your dependents pregnant? Yes__ No__ If so, which trimester? 1st__ 2nd__ 3rd__

4. Are you or any of your dependents anticipating surgery or had surgery recommended which has not been performed? Yes__ No__ Explain:

5. Have you or any of your dependents ever had or been told they had or been treated for any disease or disorder of the: heart__ muscles__ immune disorder__ lung or respiratory disorder__ cancer__ diabetes__ nervous or mental disorder__ alcohol or drug abuse__ arthritis__ seizure disorder__ kidneys__ stomach or intestines__ reproductive system__ liver disease__ ulcers__ hernia__ rheumatism__ urinary disorder__ asthma__ shortness of breath__ high blood pressure__ fainting/dizziness__

Name	Condition	From – To	Treatment	Any Remaining Effects