AMERIHEALTH DELAWARE

Individual Health Questionnaire 1-15 Employees

GROUP/EMPLOYER NAME _____

Employee
Name _____ Social Security # _____ Date of Birth _____ Ht _____ Wt _____
Spouse's
Name _____ Social Security # _____ Date of Birth _____ Ht _____ Wt _____

Prior Carrier _____ Coverage Date --- From: _____ To: _____

Coverage Tier ☐ Single ☐ Employee & Spouse ☐ Parent/Children ☐ Family

HEALTH HISTORY *Include information on yourself and any of your dependents listed for coverage. Answer each question by checking "YES" or "NO". For every "YES" answer, please provide details below.*

1. Have you or any dependent to be covered had, or been advised that you or they have or may have had: ____ Yes ___ No

- Acquired Immune Def. Syndrome AIDS
- AIDS Related Complex (ARC) or HIV
- Excessive use of Alcohol or Alcoholism
- Back or neck disorder, injury or pain
- Cancer or tumors
- Heart disorder or condition or chest pain
- Diabetes
- Epilepsy
- Gastro or intestinal disorder
- Stroke, or other circulatory disorders
- Any immune system disorder
- Kidney or liver disorder
- Lung or respiratory disorder
- Lymph node disorder
- Any sexually transmitted disease
- Ulcers
- High Blood Pressure
- Asthma

2. Are you or any of your dependents pregnant? (If YES, indicate due date _____) ____ YES ___ NO

3. In the past 12 months, have you or any of your dependents?
   a. Gained or lost 20 or more pounds? ____ YES ___ NO
   b. Been examined or treated by a physician or other health care provider? ____ YES ___ NO
   c. Been prescribed medication(s) ____ YES ___ NO
   d. Been advised to have any special examinations, treatment, surgery or testing? (Examples: x-rays, electrocardiograms, blood or urine tests) ____ YES ___ NO

4. In the past 24 months, have you or any of your dependents smoked, chewed or snuffed tobacco? ____ YES ___ NO

5. In the past 5 years, have you or any of your dependents been disabled, hospitalized, or had a surgical operation? ____ YES ___ NO

6. Have you or any of your dependents been counseled or advised that you or they may have any disease, disorder, impairment, deformity, and injury, chronic or untreatable condition (whether active or in remission)? ____ YES ___ NO

7. Do you or any of your dependents have any prosthetic device or implant? ____ YES ___ NO

Please provide details here for any "YES" answer to questions 1-7. If more space is required, attach additional sheets. Be sure to sign and date each additional sheet.

Question Number	Name of Person Treated	Condition	Dates		Explain Treatment,inc. dates of surgery, hospitalization, medication (incl. dosage and frequency), test results and outcome.	Names and addresses of health care providers and facilities
			From	To		

I certify that all information above is true and complete to the best of my knowledge and belief. I authorize any hospital, skilled nursing facility, health maintenance organization, pharmacy, physician, dentist, pharmacist, professional review organization and any and all other providers of service to disclose and furnish to AmeriHealth Insurance Co. and AmeriHealth HMO and/or to its agents any and and all records relating to me and any of my dependents for whom services or benefits have been sought or benefits have been provided, including, but not limited to any information relating to treatment for drug or alcohol abuse and information relating to Acquired Immune Deficiency Syndrome (AIDS) or HIV infection, to the extent of providing complete diagnostic and medical information.
Any person, who knowingly files a statement of claim, application for insurance, enrollment form, or certification containing any false or misleading information may be subject to criminal and civil penalties.

_____ _____
Employee Signature **Date**