

MEDICAL QUESTIONNAIRE

Vernon County

EMPLOYEE INFORMATION

*All fields **must** be completed in order to qualify for coverage. Please print clearly.*

Name: _____ Date of Birth: _____ Gender: M / F
 Social Security Number: _____ Marriage Status: Single / Married / Divorced
 Daytime Phone #: _____ Email Address: _____
 Home Address: _____
 City: _____ State: _____ Zip Code: _____ Hire Date: _____

MEDICAL HISTORY INFORMATION

Have you or anyone covered by your medical plan received consultation or treatment for any of the following conditions in the past two (2) years? *(Please check **all** that apply. If you check **any box** in this section, you **must complete** the GBS Release of Information Authorization form in addition to this questionnaire.)*

- | | | |
|--|--|---|
| <input type="checkbox"/> Any Pending Surgery or Condition with More Than \$10k in Claims | <input type="checkbox"/> Connective Tissue Disorder(s) | <input type="checkbox"/> Lung Disease/Disorder(s) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> CVA/Stroke | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Back/Joint Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Myasthenia Gravis |
| <input type="checkbox"/> Cancer/Neoplasm/Lymphoma | <input type="checkbox"/> Heart or Blood Disorder(s) | <input type="checkbox"/> Neurological Disorder(s) |
| <input type="checkbox"/> Cerebral Palsy / Cystic Fibrosis | <input type="checkbox"/> Hyper or Hypothyroid | <input type="checkbox"/> Pregnancy Complications |
| <input type="checkbox"/> Chronic Psychiatric Disorder(s) | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal Disorder(s) |
| <input type="checkbox"/> Congenital Disorder | <input type="checkbox"/> Injury or Injuries | <input type="checkbox"/> Sickle Cell |
| | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Stomach/Intestinal Disorder(s) |
| | <input type="checkbox"/> Liver Disorder(s) | |

Please explain below all conditions checked above. Additional space is available on the back of this form.

PATIENT NAME	RELATIONSHIP	CURRENT DIAGNOSIS	DATE DIAGNOSED (MM / YYYY)	TYPE OF ONGOING CARE	PRESCRIPTION MEDICATIONS?

AGREEMENT AND SIGNATURE

I certify that the information I provided on this medical questionnaire form is true and accurate to the best of my knowledge. I understand that intentional misstatements on this form may constitute fraud and that such fraud **will** result in the rescission of coverage.

I understand that the information provided on this form shall not be utilized to determine if I or any of my dependents are eligible to enroll in coverage. I understand the information on this form will be utilized to determine benefit availability according to the plan sponsored by my employer.

Signature: _____ Date: _____