PARAMOUNT

Employee Medical History

CONFIDENTIAL

EMPLOYER, SELF AND DEPENDENT INFORMATION

1. Employer_____ **Occupation**_____

Yrs W/Company (circle): <1 1-3 4+ **Employee ZipCode**_____

	Full Name (eligible dependents)	**Social Security #**	**Date of Birth** (MM/DD/YY)	**Sex** (M or F)	**Height** (feet-inches)	**Weight** (lbs)
Self						
Spouse						
1						
2						
3						
4						
5						

2. MEDICAL QUESTIONS (explain all YES answers in Section 5 for questions A thru J only)

	YES	NO
A) Within the past 5 years, have you or any of your dependents had, or been treated for, or been told that you have any other condition / disorder / disease not listed in section **2** or **3**?	☐	☐
B) Within the past 5 years, have you or your dependents had Surgery, an EKG, X-Ray, or any other diagnostic test? Or been hospitalized for examination or treatment?	☐	☐
C) Are you or any of your dependents applying for coverage been advised to have surgery, EKG, X-Ray or any other diagnostic test in the near future? Been advised to enter a hospital or institution for examination or treatment?	☐	☐
D) Are you or any of your dependents currently pregnant? If so, state expected due date _____/_____/_____	☐	☐
E) Within the past 5 years, have you or your dependents been on fertility drugs, had a high risk pregnancy, abnormal pap test, or a venereal disease?	☐	☐
F) Have you or any of your dependents had any physician office visits, ER visits, Inpatient or Outpatient services in the last 90 days?	☐	☐
G) Are you or any of your dependents currently taking any prescription medications? (**Will be requested to list in section 4**)	☐	☐
H) Do any of the conditions listed on this form involve Worker's Compensation? If YES, provide the Worker's Compensation Case Number: #_____	☐	☐
I) Have you or your dependents ever been restricted from, or declined for coverage by any carrier?	☐	☐
J) Are you or your dependents likely to have a continuing claim for a present mental or physical disorder?	☐	☐
K) Do **you** SMOKE cigarettes, cigars, or use any other form of tobacco/nicotine? If YES, for how many years?_____how many per day?_____	☐	☐
L) Does your **spouse** SMOKE cigarettes, cigars, or use any other form of tobacco/nicotine? If YES, for how many years?_____ how many per day?_____	☐	☐

***Remember the following when completing:**

- **In completing this application and answering questions herein, you should not include any genetic information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe you and/or your dependents may be at risk**
- **Boxes checked yes require explanation in section 4 & 5.**
- **Please provide details, dates, start and end of treatment for all conditions.**
- **Include Zip Code, height, weight and Social Security Number(s) for all applicants.**
- **Incomplete information will delay the underwriting process!**

3. MEDICAL CONDITIONS (Explain all checked conditions in Section 5)

CHECK all medical conditions, diseases and treatments listed below for which you or any of your dependents have, or have ever been, diagnosed, treated or counseled.

I. CANCEROUS CONDITIONS AND PROCEDURES

- □ a) Type_____ _____
- □ b) Lymph node involvement Yes □ No □
- □ c) Chemotherapy Yes □ No □
- □ d) Radiation Therapy Yes □ No □
- □ e) Other

II. ENDOCRINE

(Provide last three blood sugar counts or A1C And dates in EXPLANATION Section 4.)

- □ a) Juvenile (Type I)
- □ b) Adult (Type II)
- □ c) Diabetes (Diet/Exercise)
- □ d) Liver Disorder
- □ e) Hepatitis: Type_____
- □ f) Pituitary Disorder
- □ g) Thyroid
- □ h) Other

III. IMMUNE DISORDERS

- □ a) AIDS
- □ b) HIV
- □ c) Immuno Deficiency
- □ d) Other

IV. TRANSPLANTS

- □ a) Transplant: Date_____ Type_____
- □ b) Potential future transplant? Details_____
- □ c) Other

V. URINARY/BLADDER

- □ a) Bladder disorder
- □ b) Chronic Kidney disease
- □ c) Kidney stones
- □ d) Polycystic kidney disease
- □ e) Kidney dialysis/ Renal Start date:_____
- □ f) Kidney failure/ Renal Failure
- □ g) Prostate disorder
- □ h) Other

VI. HEART AND CIRCULATORY SYSTEM CONDITIONS AND PROCEDURES

- □ a) Anemia
- □ b) Aneurysm: Type_____ Operated Yes □ No □
- □ c) Angina
- □ d) High Blood Pressure/Hypertension
- □ e) Bypass Surgery: Date(s)_____
- □ f) Angioplasty: Date(s)_____
- □ g) Congestive Heart Failure/ CHF
- □ h) Coronary Artery Disease: Date(s)_____
- □ i) Heart Attack Yes □ No □ Date(s)_____
- □ j) Hemophilia/ bleeding disorder
- □ k) High cholesterol/ Hypercholesterolemia
- □ l) Irregular Heartbeat
- □ m) Pacemaker Implant: Date_____
- □ n) Stroke: Date_____
- □ o) Thrombophlebitis (Blood clot)
- □ p) Peripheral vascular disease
- □ q) Varicosities
- □ r) Other

VII. REPRODUCTIVE

- □ a) Abnormal Pap Smear Date:_____ Normal Follow up? Date:_____
- □ b) Breast Lump, Cyst, Tumor
- □ c) Currently Pregnant Date Due:_____ High Risk Yes □ No □
- □ d) Endometriosis
- □ e) Infertility
- □ f) Menstrual Irregularities
- □ g) Other

VIII. INTESTINAL DISORDERS

- □ a) Diverticulitis
- □ b) Crohn's disease
- □ c) Gastric bypass/ banding
- □ d) Gall stones Operated Yes □ No □
- □ e) GERD/ reflux
- □ f) Ulcer
- □ g) Ulcerative colitis
- □ h) Other

IX. NEUROLOGICAL

- □ a) Epilepsy/Seizure (Provide date of last seizure) _____
- □ b) Migraines
- □ c) Multiple Sclerosis Neurological disability Yes □ No □
- □ d) Fainting spells
- □ e) Paralysis
- □ f) Head injury
- □ g) Other

X. RESPIRATORY SYSTEM CONDITIONS

- □ a) Allergy/ Asthma
- □ b) Cystic Fibrosis
- □ c) Emphysema/ COPD Oxygen Yes □ No □
- □ d) Pneumonia
- □ e) Sleep Apnea
- □ f) Tuberculosis
- □ g) Other

XI. MUSCULAR/ SKELETAL

- □ a) Arthritis □ Rheumatoid □ Osteo
- □ b) Back/Spinal disorder
- □ c) Degenerative disease
- □ d) Fracture
- □ e) Joint Injury_____ Replacement_____
- □ f) Amputation/ prosthesis
- □ g) Other

XII. PSYCHOLOGICAL

- □ a) ADHD/ ADD
- □ b) Alcohol/ drug abuse
- □ c) Anxiety/ depression
- □ d) Bi-polar
- □ e) Eating disorder
- □ f) Schizophrenia
- □ g) Suicide attempt
- □ h) Other

4. Please provide all current prescription information for you and your dependents.

Individual's Full Name	Medication & Dosage	Start date	Condition (be Specific)

5. Provide the requested information for each Condition/Question checked YES in Section 2 & 3.

Condition Question # Individual's Full Name	Physician's Name and address	Treatment Dates (From/To)	Diagnosis, Treatment & Prognosis (be specific)

6. TERMS AND CONDITIONS

I authorize Paramount:

1. The release of information without limitation, to evaluate this questionnaire including any and all copies of records concerning advice, care, or treatment provided to me or my dependent(s) from any medically related facility, government agency or person which may include pharmacy and or drug records or history.
2. To have any hospital, pharmacy benefits manager, pharmacy or physicians furnish such medical information as may be required for my dependents or myself.
3. The release of information from a professional utilization review program of health services on behalf of me and my dependent(s).
4. The use and disclosure of any personal information concerning me and/or my dependents that is contained on any application for health insurance coverage that I have completed unless revoked earlier expires 30 months after the date of this authorization, including any individually identifiable health information contained in this questionnaire or obtained through a consumer reporting agency.

I understand that:

1. Any untrue or incomplete information, statements or answers on this questionnaire (whether intentional or not), can result in the denial of a claim or rescission of coverage and may be subject to legal action.
2. To be eligible for coverage I must be an active full time employee working a minimum of 25 hours per week. Eligible employee does not include a temporary or substitute employee, or a seasonal employee who works only part of the calendar year on the basis of natural or suitable times or circumstances.
3. This form will not be used for the purpose of determining whether insurance coverage will be extended.
4. This authorization will not affect any health care treatment plan required.
5. I may revoke this authorization at any time by notifying Paramount in writing at 1901 Indian Wood Circle, Maumee, OH 43537-4068, except to the extent that action has already been taken in reliance on this authorization.
6. I have a right to ask for and receive a copy of this authorization.
7. Paramount reserves the right to change the schedule of premiums applicable to your employer group based on updated, revised or additional information provided in such application.
8. There is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may not longer be protected by federal rules governing privacy and confidentiality.
9. The purpose of the disclosure and use of this information is to allow Paramount to make decisions regarding eligibility, underwriting, and premium risk rating.

• Preferred language (used for healthcare)	Race. (Check all that apply)	Ethnic Background
☐ English	☐ Black/African American	☐ Hispanic or Latino
☐ Spanish	☐ White	☐ Not Hispanic/Latino
☐ American Sign Language (ASL)	☐ Nat American / AN	
☐ Braille	☐ Native Hawaiian / Pacific Islander	
☐ Other_____	☐ Asian / Asian American	

I have read all of the above statements contained in this medical history questionnaire and declare by signing this questionnaire that the information provided by me is true and complete and to the best of my knowledge

WARNING: *Any person who, with intent to defraud or knowing that he is facilitating fraud against any insurer, submits any application or files a claim containing a false or deceptive statement is guilty of insurance fraud.* (Revised 5.6.2011)

7. SIGNATURES – Sign after completing and reading all applicable sections.

By signing below I signify full understanding and acceptance of the terms indicated above.

_____ _____ _____ _____

Your Signature Date Your Spouse's Signature (if applying for dependent coverage) Date