# Application for Individual Health Insurance

## Please read the following instructions for completing this application:

- This application is a legal document and will become part of your contract if you are approved for coverage. You must provide **all** requested information and ensure it is accurate and legible.
- This application is created in a writeable PDF. You can save it to your computer to fill out. **If you do not have the latest version of Adobe Reader, please visit adobe.com for a free download.** You can also print the application and fill it out in either black or dark blue ink.
- If you make a mistake on the printed application, please mark through the incorrect information, initial it and then provide the correct information.
- On the printed application, do not use correction fluid or correction tape to correct any mistakes you make.
- Any attached sheets containing additional information must be signed and dated by the applicant.
- Please ensure that all required parties sign and date the application. A digital signature is available on the writeable PDF.
- Please do not send money with this application.
- We strongly encourage you to save a copy to your computer or to make a photocopy of this completed application for your records.

## Once the IQChoice application has been completed, you can submit by:

| **FAX**<br>Printed Application to: | **MAIL**<br>Printed Application to: |
|---|---|
| 866.645.1788 | QualChoice<br>Attn: IQChoice<br>P.O. Box 2<br>Little Rock, AR 722  1 |

## Policy Effective Date

The policy effective date will be the 1st of the month following the month in which the application for coverage is approved. Coverage becomes effective upon the date of the policy and contingent upon receipt of premium.

# Application for Health Insurance

## 1. WHO IS APPLYING

In the RELATIONSHIP box below, please indicate spouse, son, daughter, stepson, or stepdaughter beside each dependent's name. **Please submit immunization records for all dependents one (1) year old or less. IMPORTANT:** Stepchildren who apply for coverage must reside with the proposed insured. If any other dependents named on this application do NOT reside with the proposed insured, we must also have the custodial parent's signature. See page 8 of this application. **Dependents age 19 through 24 must be full-time students at an accredited school.** If a guardianship or custodial relationship exists, please attach appropriate court documents.

| FIRST NAME | M.I. | LAST NAME | SUFFIX | RELATIONSHIP | SEX | BIRTH DATE | SOCIAL SECURITY NUMBER | HEIGHT | WEIGHT |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

## 2. PARENT/GUARDIAN (If policy is only for a child under age 18)

| FIRST NAME | M.I. | LAST NAME | RELATIONSHIP (**Check One**) |
|---|---|---|---|
| | | | ☐ Father ☐ Stepfather ☐ Guardian<br>☐ Mother ☐ Stepmother |

## 3. STUDENT INFORMATION (Dependent[s] age 19 through 24; Must be full-time student[s])

| DEPENDENT | SCHOOL ATTENDING | SCHOOL ADDRESS | SEMESTER HOURS | ESTIMATED DATE OF GRADUATION |
|---|---|---|---|---|
| | | | | _________/20_____ |
| | | | | _________/20_____ |

## 4. MARITAL STATUS

☐ Single (including widowed and divorced) ☐ Married (including separated)

## 5. U.S. CITIZENSHIP STATUS

☐ Yes ☐ No Are all applicants U.S. citizens?

If NO, please provide the name(s) of the applicant(s) who are **not** U.S. citizens.

Applicant (list all that apply): ____________________________________________________________

**Applicants who are not U.S. citizens will be required to complete a Foreign National Questionnaire prior to the processing of their application. Please contact the IQChoice Sales Manager at (866) 645-1790 to request the Foreign National Questionnaire.**

## 6. RESIDENTIAL ADDRESS (No P.O. Box, please)

| PERMANENT RESIDENCE STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

## 7. MAILING ADDRESS (Complete only if **different** from residential address)

| MAILING STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

## 8. BILLING ADDRESS (Complete only if **different** from residential address)

| BILLING STREET ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | | |

## 9. E-MAIL ADDRESS

E-mail Address: ______________________________________________________________________________

We will not provide your e-mail address to anyone outside of QualChoice.

## 10. CONTACT INFORMATION

| PRIMARY PHONE NUMBER | SECONDARY PHONE NUMBER | BEST TIME TO CALL |
|---|---|---|
| | | AM PM |

## 11. HOUSEHOLD INFORMATION

☐ Yes ☐ No Do all applicants reside in the same household?

If NO, provide reason: ______________________________________________

☐ Yes ☐ No Do all applicants reside in Arkansas?

If NO, provide reason and address:______________________________________________

## 12. EMPLOYMENT INFORMATION (Applicant[s] age 18 and older)

Applicant: ______________________ Employer: ______________________

Occupation: ______________________ Job Duties: ______________________

☐ Yes ☐ No Is this applicant a sole proprietor?

☐ Yes ☐ No Is this applicant covered under workers' compensation?

☐ Yes ☐ No Does this applicant's employer employ three or more full-time workers?

Applicant: ______________________ Employer: ______________________

Occupation: ______________________ Job Duties: ______________________

☐ Yes ☐ No Is this applicant a sole proprietor?

☐ Yes ☐ No Is this applicant covered under workers' compensation?

☐ Yes ☐ No Does this applicant's employer employ three or more full-time workers?

## 13. CURRENT INSURANCE INFORMATION

☐ Yes ☐ No Has any applicant been covered by an employer-sponsored health plan within the past 63 days?

If YES, and the **coverage** has a specified termination date, please provide it here: ___________/___________/20_________

☐ Yes ☐ No Has any applicant ever been covered by QualChoice or QCA Health Plan, Inc.?

☐ Yes ☐ No Are any applicant eligible for an employer-sponsored group health plan?

☐ Yes ☐ No Are any applicant covered by Medicare?

If YES, please provide the following information:

Applicant: ______________________ HIC #: ______________________Effective Date: ______/______/________

Applicant: ______________________ HIC #: ______________________Effective Date: ______/______/________

## 14. DRIVER'S LICENSE INFORMATION (Applicants age 15 and older)

Applicant: ______________________ License Number: ______________________ State Issued: ______________

Applicant: ______________________ License Number: ______________________ State Issued: ______________

Applicant: ______________________ License Number: ______________________ State Issued: ______________

☐ Yes ☐ No Has any applicant had his/her driver's license suspended within the past two (2) years?

☐ Yes ☐ No Has any applicant had his/her driver's license revoked within the past five (5) years?

☐ Yes ☐ No Has any applicant been convicted or charged with driving under the influence of alcohol or a controlled substance within the past five (5) years?

If YES to any of the above questions, please provide the following information:

Applicant: ______________________ Violation: ______________________ Date of Occurrence: ____________

Applicant: ______________________ Violation: ______________________ Date of Occurrence: ____________

## 15. SPORTING OR HOBBY INFORMATION

☐ Yes ☐ No Does any applicant intend to pilot a private aircraft; race a motor vehicle, boat, or snowmobile; or participate in sky or scuba diving, ballooning, mountain climbing, hang gliding, or any other hazardous sport, hobby, or activity?

Applicant: ______________________ Please Explain: ______________________

Applicant: ______________________ Please Explain: ______________________

## 16. TRAVEL OUTSIDE OF THE UNITED STATES

☐ Yes ☐ No Is any applicant planning to travel or work outside of the **United States** for more than thirty (30) days within the next two (2) years?

If YES, please provide the following information:

Applicant (list all that apply): ______________________ Country: ______________________

Reason for Travel: ______________________ Expected Length of Stay: ______________

## 17. EXPECTANT/ADOPTIVE PARENT INFORMATION

☐ Yes ☐ No Is any **male** applying for coverage an expectant parent or potential adoptive parent?

☐ Yes ☐ No Is any **female** applying for coverage an expectant parent or potential adoptive parent?

If YES to either question above, please provide the following information:

Applicant: ___________________________________ Expected Delivery/Adoption Date: ________________________

## 18. TOBACCO USAGE INFORMATION

☐ Yes ☐ No Has any applicant used **any** form of tobacco within the last five (5) years?

If YES, please provide the following information:

Applicant: ______________ Year Began: _______ Type Used: _______________ Amount Used Per Day: ___________

Applicant: ______________ Year Began: _______ Type Used: _______________ Amount Used Per Day: ___________

Applicant: ______________ Year Began: _______ Type Used: _______________ Amount Used Per Day: ___________

## 19. PREVIOUS INSURANCE EXPERIENCE INFORMATION

☐ Yes ☐ No Has any applicant ever been declined for the issue of life, accident, or health insurance?

If YES, please provide the following information:

Applicant: ______________ Year: _______ Carrier: _________________ Reason for Decline: ___________________

Applicant: ______________ Year: _______ Carrier: _________________ Reason for Decline: ___________________

Applicant: ______________ Year: _______ Carrier: _________________ Reason for Decline: ___________________

## 20. PRESCRIPTION QUESTIONNAIRE

☐ Yes ☐ No Is any proposed applicant **currently** taking any prescription medication or has any applicant taken prescription medication in the **last 3 years**?

If YES, please provide full detail below. Use a separate sheet if necessary. **Any attachment must include all of the same information requested here and must be signed and dated.** A pharmacy print out is **not** acceptable. **Please use the name that would have been given at the time of the prescription – e.g., a maiden name may have been used.**

| Person Treated | Name of Prescription | Dosage | Specific Condition/Illness | Start Date/Stop Date | Degree of Recovery | | | Physician Name & Address |
|---|---|---|---|---|---|---|---|---|
| | | | | | None | Partial | Full | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## 21. APPLICANT PHYSICIAN INFORMATION

☐ Yes ☐ No Has the applicant seen a physician in the last five (5) years?

If yes, please provide the name, address, and phone number of each applicant's physician (group applicants with the same physician together).

| Applicant(s) | Physician Name | Physician Address | Physician Phone Number | Date of Last Visit |
|---|---|---|---|---|
| | | | | |
| | | | | |

## 22. MEDICAL QUESTIONNAIRE

**ALL OF THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR EACH PERSON APPLYING FOR COVERAGE.**
Check "Yes" or "No" if any applicant has had or been told he/she had any of the conditions listed below in the past five (5) years. Once complete, you must continue to the Secondary Medical Questionnaire and answer those sections marked YES below.

| Yes | No | Condition |
|---|---|---|
| ☐ Yes | ☐ No | 1. Diabetes/Sugar in Urine/Elevated Blood Sugar (Page 9) |
| ☐ Yes | ☐ No | 2. High Blood Pressure/Hypertension (Page 9) |
| ☐ Yes | ☐ No | 3. Endocrine System/Thyroid/Parathyroid/Cushing's Disease/Growth Hormone Deficience/Addison's Disease (Page 9) |
| ☐ Yes | ☐ No | 4. Ears/Eyes/Nose/Throat/Skin Conditions/Burns (Pages 9-10) |
| ☐ Yes | ☐ No | 5. Heart/Circulatory/Stroke/Aneurysm/Cholesterol/Blood Clots/Anemia/Peripheral Vascular Disease/Swelling of the Extremities/Valve Disorder (Pages 10) |
| ☐ Yes | ☐ No | 6. Infertility/Reproductive Organ Disorder/STD/Hypertrophy/Prostate/Ovarian Cysts/Abnormal Pap Smears (Page 11) |
| ☐ Yes | ☐ No | 7. Digestive/Intestinal/Liver Disorder/Acid Reflux/GERD/Ulcers/Crohn's Disease/Gastrointestinal Bleeding/ Diverticulitis/Gall Bladder Disease/Hernia/Colitis/Colon Polyps/Pancreatitis (Page 11) |
| ☐ Yes | ☐ No | 8. Nervous System/Brain Disorder/Headache/Multiple Sclerosis/Alzheimer's Disease/Senility/Dementia/Heat Exhaustion/Heat Stroke/Neuroma/Paralysis/Meningitis(Page 12) |
| ☐ Yes | ☐ No | 9. Mental or Nervous Condition/Depression/Panic Disorder/Anxiety Disorder/Bipolar Disorder/Eating Disorder/ ADD/ADHD (Page 12) |
| ☐ Yes | ☐ No | 10. Back or Neck Disorder/Ankylosing Spondylitis/Muscle Spasm/Sciatica/Scoliosis (Page 12-13) |
| ☐ Yes | ☐ No | 11. Muscular Disorder/Lupus/Fibromyalgia/Ligament Tears/Muscle Tissue Abscess/Myositis (Page 13) |
| ☐ Yes | ☐ No | 12. Cancers/Tumors (Malignant or Benign) (Pages 13) |
| ☐ Yes | ☐ No | 13. HIV/AIDS/ARC (Page 13) |
| ☐ Yes | ☐ No | 14. Epilepsy/Seizure Disorder (Page 14) |
| ☐ Yes | ☐ No | 15. Drug or Alcohol Abuse (Page 14) |
| ☐ Yes | ☐ No | 16. Urinary Tract/Kidney Disorder/Renal Failure (Page 14) |
| ☐ Yes | ☐ No | 17. Respiratory/Lung Disorder/TB/Allergies/Asthma/Shortness of Breath (Page 14) |
| ☐ Yes | ☐ No | 18. Arthritis/Bone/Joint/TMJ/Fractures (Pages 15) |
| ☐ Yes | ☐ No | 19. Other Illness, Disease or Injury (Page 15) |
| ☐ Yes | ☐ No | 20. Abnormal Laboratory Results (Page 15) |
| ☐ Yes | ☐ No | 21. Hospitalized or Confinement for 10 Days or more (Page 16) |
| ☐ Yes | ☐ No | 22. Weight Gain/Loss of 15 More Pounds in Past 12 Months (Page 16) |

## 24. OPTIONAL BENEFIT RIDER SECTION

Check "Yes" or "No" for the optional benefit riders you wish to add to your benefit plan.
**IMPORTANT**: Rejection of the TMJ rider means that covered benefits will not include coverage for temporomandibular joint disorder or craniomandibular disorder. Rejection of the maternity rider means that covered benefits will not include coverage for maternity.

☐ Yes ☐ No Maternity (Pregnancy)

If YES, please provide name of physician: ____________________

☐ Yes ☐ No Temporomandibular Joint Disorder (TMJ)

If YES, please provide name of dentist and physician:

Dentist: ____________________ Physician: ____________________

☐ Yes ☐ No Mental Health

If YES, please provide name of physician: ____________________

## PLEASE READ BEFORE SIGNING

I UNDERSTAND: (1) This application may be rejected, therefore, I understand that I should not cancel any coverage I currently have until I am notified of QualChoice's decision. (2) If accepted, the insurance applied for shall not become effective until the date shown on my identification card and the initial premium is paid in full, but in no event will insurance become effective earlier than 10 days after the date of this application. (3) The agent or broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker. (4) In addition to other exclusions and limitations, **no QualChoice benefits will be available for 12 months for the treatment of any condition which existed before the effective date of my coverage.** (5) If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information. (6) I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies. (7) My signature authorizes QualChoice to coordinate benefits under this policy with other insurance I have which is subject to coordination. (8) QualChoice may phone me for additional information that may help with the timely processing of my application.

In signing below, I: (a) represent that the statements and answers given in this application and any signed and dated addendum to this application (both front and back) are true, complete and correctly recorded; (b) authorize any physician, medical practitioner, hospital, clinic or other medically related facility, employer, health plan, the Medical Information Bureau (MIB), insurance or reinsurance company or any third party engaged by QualChoice to secure medical or non-medical information having information with respect to any physical or mental condition, treatment or any non-medical information on me, or any member of my family (if applicable), to give QualChoice or its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (c) authorize all said sources to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (d) agree that this authorization shall be valid without time limit; (e) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request; (f) and authorize the Office of Driver Services to release my traffic violation record to QualChoice; and (g) QualChoice may release any information obtained by it about me or any member of my family to MIB or any member company for purposes described in QualChoice's Notice of Information Practices.

**I certify that I signed this application in the state of Arkansas.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

## SIGNATURE SECTION (Please sign appropriate line only)

| | | |
|---|---|---|
| Proposed Insured's Signature<br>**OR**<br>Parent's/Legal Guardian's Signature<br>**(required if applying)** | X | Date Signed |
| Spouse's Signature<br>**(required if applying)** | X | Date Signed |
| Adult Signature | X | Date Signed |

## CUSTODIAL PARENT SIGNATURE SECTION

| **If any dependents named on this application do NOT reside with the proposed insured, the custodial parent's signature is required.** | | |
|---|---|---|
| Custodial Parent's Name and Address<br>**(please print)** | | |
| Custodial Parent's Signature | X | Date Signed |

## THIS SECTION TO BE COMPLETED BY BROKER/AGENT

| | | |
|---|---|---|
| ☐ Yes ☐ No | To the best of your knowledge, will the coverage applied for replace or change any existing hospital, medical, or major medical insurance if this coverage is approved by QualChoice and accepted by the applicant? | |
| Broker/Agent License # | Broker/Agent Name (Please Print)<br>X | Telephone Number |
| Agency Federal Tax ID #<br>(If applicable) | Broker/Agent Signature<br>X | Date Signed |
| Broker Agency Name | Broker/Agent E-mail | |

# IMPORTANT:

**We cannot process your application without this completed form.**

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of my enrollment in the policy, I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records of me or my health to provide QualChoice, or its reinsurers, information concerning services or supplies provided to me or to any family member listed on my application. I authorize any prior insurance carrier to furnish information concerning me and/or my family members listed on my application. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice Notice of Privacy Practices. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me and any family members listed in my application to my broker or agent. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice. I understand that I may terminate this authorization by sending a written revocation to QualChoice, 10825 Financial Centre Pkwy, Suite 400, Little Rock, AR 72211. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. A photocopy of this authorization is valid as the original. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 *et seq*. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

**This authorization must be signed by each applicant who is 18 years of age or older.**

| Print Name | Signature | Date |
|---|---|---|
| Print Name | Signature | Date |
| Print Name | Signature | Date |
| Print Name | Signature | Date |
| Print Name | Signature | Date |

## FAIR CREDIT REPORTING ACT NOTICE
## NOTICE TO PROPOSED INSURED

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to QualChoice. Your written request should be forwarded to QualChoice, Individual Underwriting Division, 10825 Financial Centre Pkwy, Ste 400, Little Rock, Arkansas 72211.

# Please Tear Off and Keep For Your Records

# Secondary Medical Questionnaire

Provide information for all sections which any applicant has had or been told he/she had any of the conditions listed below in the past five (5) years. Any person who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**1. Diabetes/Sugar in Urine/Elevated Blood Sugar** ☐ Yes ☐ No

Which applicant(s) has diabetes?

_____________________________________________

Which type of diabetes has been diagnosed?

☐ Type I
☐ Type II
☐ Gestational

**2. High Blood Pressure/Hypertension** ☐ Yes ☐ No

Which applicant(s) has high blood pressure?

_____________________________________________

Three recent blood pressure readings in systolic/diastolic format:

| Systolic | Diastolic | Date Taken |
|---|---|---|
| | | |
| | | |
| | | |

| | Yes | No |
|---|---|---|
| Were the readings taken while on meds for hypertension? | ☐ | ☐ |
| Is the applicant also diagnosed with malignant hypertension? | ☐ | ☐ |
| Is the Hypertension controlled by diet and exercise | ☐ | ☐ |

**3. Endocrine System/Thyroid** ☐ Yes ☐ No

Which applicant(s) has an endocrine system/thyroid condition?

_____________________________________________

| | Yes | No |
|---|---|---|
| Hyperthyroidism/Hashimoto's Thyroiditis/ Graves Disease (excess thyroid hormone) | ☐ | ☐ |
| What kind of treatment has the applicant had for this condition? ☐ Surgery ☐ Radioactive Iodine ☐ Other | | |
| If SURGERY, date it was done (MM/YYYY): | ____/_______ | |
| Does medical management control the disease? | ☐ | ☐ |
| Hypothyroidism (low thyroid hormone) | ☐ | ☐ |
| Toxic Thyroid Goiter (Plummer's Disease) | ☐ | ☐ |
| When was the diagnosis made (MM/YYYY)? | ____/_______ | |
| Hyperparathyroidism | ☐ | ☐ |
| Did the applicant have surgery for this condition? | ☐ | ☐ |
| If NO, does medication control disease? | ☐ | ☐ |
| If YES, provide date of surgery (MM/YYYY): | ____/_______ | |

| | Yes | No |
|---|---|---|
| Hyperaldosteronism (Cushing's Disease) | ☐ | ☐ |
| Is the cause of disease known? | ☐ | ☐ |
| IF YES, describe cause: ________________________________________ ________________________________________ ________________________________________ | | |
| Date condition diagnosed (MM/YYYY): | ____/_______ | |
| Is the condition stable with treatment? | ☐ | ☐ |
| Addison's Disease (Chronic Adrenal Insufficiency) | ☐ | ☐ |
| Growth Hormone Deficiency | ☐ | ☐ |
| Other Thyroid/Endocrine System Disorder | ☐ | ☐ |
| Please describe: ________________________________________ ________________________________________ | | |

**4. Ear/Eye/Nose/Throat/Skin** ☐ Yes ☐ No

Which applicant(s) has an EENT or skin condition?

_____________________________________________

| | Yes | No |
|---|---|---|
| Middle Ear Infections/Tubes in Ears/Otitis Media | ☐ | ☐ |
| Are infections chronic? | ☐ | ☐ |
| How many infections have occurred in the past twelve (12) months? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+ | | |
| Are tubes present in the ear canals? | ☐ | ☐ |
| Date of most recent episode (MM/YYYY): | ____/_______ | |
| Severe Burns (Thermal or Radiation Burns) | ☐ | ☐ |
| Were burns 1st degree? | ☐ | ☐ |
| If YES, is the applicant currently under care for? | ☐ | ☐ |
| If NO, date treatment was complete (MM/YYYY): | ____/_______ | |
| Were burns 2nd or 3rd degree? | ☐ | ☐ |
| If YES, which body parts were affected? ☐ Head and neck ☐ Abdomen ☐ One arm-unilateral ☐ One leg-unilateral ☐ Both arms-bilateral ☐ Both legs-bilateral ☐ Chest | | |
| If YES, were there deep burns to any of the following areas? ☐ Face ☐ Ears ☐ Hands ☐ Feet ☐ Eyes ☐ Perineum | | |

| | Yes | No |
|---|---|---|
| Inhalation Burns (Chemical or Electrical Burns) | ☐ | ☐ |
| Psoriasis | ☐ | ☐ |
| Episodes are: ☐ Mild ☐ Severe | | |
| Cellulitis (Skin Infection) | ☐ | ☐ |
| Was there more than one episode? | ☐ | ☐ |
| Are the episodes severe? | ☐ | ☐ |
| When was the last episode (MM/YYYY)? | ____/_______ | |
| Cleft Palate | ☐ | ☐ |
| Has there been surgery for the condition? | ☐ | ☐ |
| If YES, when was the surgery (MM/YYYY)? | ____/_______ | |
| If YES, is further surgery needed? | ☐ | ☐ |
| Cataracts | ☐ | ☐ |
| Does this condition affect both of the applicant's eyes? | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ |
| If YES, date surgery completed (MM/YYYY): | ____/_______ | |
| Tonsillitis | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ |
| Was there more than one episode of symptoms? | ☐ | ☐ |
| Date of last episode of symptoms (MM/YYYY): | ____/_______ | |

Yes No

**4. Ear/Eye/Nose/Throat/Skin (Continued)**

Sinusitis/Sinus Infection ☐ ☐

Is this condition chronic? ☐ ☐

Other Ear/Eye/Nose/Throat or Skin Condition ☐ ☐

Please describe:

________________________________________

________________________________________

________________________________________

Yes No

**5. Heart/Circulatory/Stroke/Aneurysm** ☐ ☐

Which applicant(s) has a heart/circulatory system condition?

_____________________________________________

Hypercholesterolemia/Hyperlipidemia/High Blood Lipids/ High Blood Cholesterol ☐ ☐

Is this condition secondary to another condition? ☐ ☐

If YES, describe condition:

________________________________________

________________________________________

What are the cholesterol levels (in mg/dl)?

☐ -220 ☐ 221-250 ☐ 251-300 ☐ 301+

Are the above levels while on cholesterol meds? ☐ ☐

Aneurysm ☐ ☐

Anemia ☐ ☐

What type of anemia does the applicant have?

☐ Pernicious ☐ Iron Deficiency

☐ Sickle Cell ☐ Hemolytic Anemia

☐ Thalassemia Major ☐ Unknown/Other

Hemophilia ☐ ☐

Bleeding Disorders ☐ ☐

What type of bleeding disorder has been diagnosed?

☐ Christmas Disease (Factor IX) ☐ Hemophilia A (Factor VIII)

☐ Oslo-Weber-Rendo Disease ☐ Other type of Hemophilia

Has there been more than 1 bleeding episode in the past year? ☐ ☐

Atrial Fibrillation ☐ ☐

Arrhythmias ☐ ☐

How many episodes have occurred?

☐ Single ☐ Multiple ☐ Chronic

If MULITPLE, are they controlled? ☐ ☐

If YES, are they controlled by drugs? ☐ ☐

If YES, are they controlled by surgical devices? ☐ ☐

Is the cause known for arrhythmias? ☐ ☐

If YES, please describe cause:

________________________________________

________________________________________

Conduction Disturbances/Bundle Branch Blocks ☐ ☐

Is the cause known for conduction disturbances? ☐ ☐

If YES, please describe cause:

________________________________________

________________________________________

Cardiac Implantable Device/Pacemaker ☐ ☐

Chest Pain/Angina/Ischemic Heart Disease/ Coronary Artery Disease ☐ ☐

Is the clinical work up suggestive of coronary artery disease/blocked cardiac arteries? ☐ ☐

If NO, date of onset of symptoms (MM/YYYY)? ____/_______

Is the cause known for chest pain? ☐ ☐

If YES, please describe cause:

________________________________________

________________________________________

Deep Vein Thrombosis/Blood Clots in Legs/Phlebitis ☐ ☐

Yes No

Does the applicant currently have one of these conditions? ☐ ☐

Has the applicant had more than one episode? ☐ ☐

If YES, date recovered from last episode (MM/YYYY): ____/_______

If NO, date of onset of symptoms (MM/YYYY): ____/_______

Is the applicant on an anti-clotting prescription? ☐ ☐

Heart Attack/Myocardial Infarction ☐ ☐

Congestive Heart Failure ☐ ☐

Carotid Artery Occlusion ☐ ☐

Cardiomegaly/Enlarged Heart ☐ ☐

Is the applicant a heart transplant candidate? ☐ ☐

Is the reason for the enlargement known? ☐ ☐

If YES, please describe:

________________________________________

________________________________________

Does the applicant have any impairment from this condition? ☐ ☐

Peripheral Vascular (Artery) Disease ☐ ☐

Claudication ☐ ☐

What is the applicant's diagnosis (choose one)?

☐ Reynaud's Disease ☐ Buerger's Disease

☐ Neither Reynaud's or Buerger's Disease

If NEITHER, date diagnosis made (MM/YYYY): ____/_______

If NEITHER, were there any amputations? ☐ ☐

If NEITHER, was there any hospitalizations? ☐ ☐

If NEITHER, please describe:

____________________________________________

Edema/Swelling of the Extremities ☐ ☐

Does the applicant know what is causing the swelling? ☐ ☐

If YES, please describe:

________________________________________

________________________________________

Cardiac Valve Disorders/Heart Murmur/Mitral Valve Prolapse/ Mitral Regurgitation/Mitral Stenosis ☐ ☐

☐ Heart Murmur ☐ Mitral Valve Prolapse

☐ Mitral Regurgitation ☐ Other Valve Disorders

☐ Mitral Stenosis

Has the applicant had surgery for this condition? ☐ ☐

Heart Transplant ☐ ☐

Cardiomyopathy ☐ ☐

Stoke ☐ ☐

Cerebral Vascular Accident (CVA)/ Transient Ischemic Attach (TIA) ☐ ☐

Pericarditis ☐ ☐

Is diagnosis restrictive pericarditis? ☐ ☐

If NO, was there only a single episode? ☐ ☐

If NO, was there any residual cardiac damage? ☐ ☐

If NO, date symptoms began (MM/YYYY) ____/_______

Other Heart or Circulatory System Disorder ☐ ☐

Please describe:

________________________________________

________________________________________

**6. Infertility/Reproductive Organ Disorder/STD** Yes ☐ No ☐

Which applicant(s) has a reproductive system condition?

_____________________________________________

| | Yes | No |
|---|---|---|
| Uterine Fibroids/Dysfunctional Uterine Bleeding | ☐ | ☐ |
| Has the applicant had a hysterectomy? | ☐ | ☐ |
| If YES, when was the surgery (MM/YYYY)? | ____/_______ | |
| Was there a malignancy? | ☐ | ☐ |
| Benign Prostatic Hypertrophy/Prostate Enlargement | ☐ | ☐ |
| Is there a malignancy? | ☐ | ☐ |
| Has the applicant had prostate surgery? | ☐ | ☐ |
| Were there any symptoms related to prostate enlargement? | ☐ | ☐ |
| Sexually Transmitted Diseases | ☐ | ☐ |
| Has the applicant ever had Genital Herpes? | ☐ | ☐ |
| If YES, date of last episode (MM/YYYY): | ____/_______ | |
| Has the applicant ever had Chlamydia? | ☐ | ☐ |
| If YES, date of last episode (MM/YYYY): | ____/_______ | |
| Has the applicant ever had Gonorrhea? | ☐ | ☐ |
| If YES, date of last episode (MM/YYYY): | ____/_______ | |
| Infertility | ☐ | ☐ |
| Ovarian Cysts | ☐ | ☐ |
| Are the cysts benign? | ☐ | ☐ |
| Are there any symptoms from this condition? | ☐ | ☐ |
| Has fhe applicant had surgery for this condition? | ☐ | ☐ |
| If YES, date of surgery | ____/_______ | |
| Has there been a reoccurrence since surgery | ☐ | ☐ |
| Cervical Dysplasia/Abnormal Pap Smears | ☐ | ☐ |
| Was there more than one abnormal Pap in the last 2 years? | ☐ | ☐ |
| Prolapsed Uterus | ☐ | ☐ |
| Has the applicant had surgery to correct the condition? | ☐ | ☐ |
| If YES, date of surgery (MM/YYYY): | ____/_______ | |
| Other Reproductive System Disorder | ☐ | ☐ |

Please describe:

_______________________________________

_______________________________________

**7. Digestive/Intestinal/Liver Disorder/Acid Reflux/GERD** Yes ☐ No ☐

Which applicant(s) has a digestive system condition?

_____________________________________________

| | Yes | No |
|---|---|---|
| GERD/Gastroesophageal Reflux Disease/Acid Reflux | ☐ | ☐ |
| Did the symptoms abate/improve with drug therapy? | ☐ | ☐ |
| Are any meds taken by the applicant prescribed by physician? | ☐ | ☐ |
| Ulcers/Peptic Ulcers/Duodenal Ulcers/Gastric Ulcers | ☐ | ☐ |
| Has the applicant had surgery for condition? | ☐ | ☐ |
| If YES, was there any recurrence since surgery? | ☐ | ☐ |
| If YES, what type of surgery was done? ☐ Subtotal Gastrectomy ☐ Total Gastrectomy ☐ Other type of surgery | | |
| If YES, date of surgery (MM/YYYY): | ____/_______ | |
| If YES, was there a diagnosis of dumping syndrome? | ☐ | ☐ |
| If NO, were there any episodes of obstruction, Hemorrhage and/or hospitalizations? | ☐ | ☐ |
| If NO, date of last episode of symptoms (MM/YYYY): | ____/_______ | |
| If NO, was there more than one episode? | ☐ | ☐ |
| Crohn’s Disease/Inflammatory Bowel Disease | ☐ | ☐ |
| Gastrointestinal Bleeding | ☐ | ☐ |
| When was the last bleeding episode (MM/YYYY)? | ____/_______ | |
| Is the applicant currently under treatment? | ☐ | ☐ |
| Diverticulitis/Diverticulosis | ☐ | ☐ |
| Does the applicant currently have symptoms from this? | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ |
| If YES, did the applicant get a colostomy? | ☐ | ☐ |
| If YES, what kind of colostomy? ☐ Permanent ☐ Temporary | | |
| If YES, were all affected portions with diverticula removed? | ☐ | ☐ |
| If NO, date of last treatment (MM/YYYY): | ____/_______ | |
| If YES, date surgery was done (MM/YYYY): | ____/_______ | |
| If NO, single episode of symptoms? | ☐ | ☐ |
| If YES, date of episode (MM/YYYY): | ____/_______ | |
| If NO, date of last episode of symptoms (MM/YYYY): | ____/_______ | |
| Cirrhosis of the Liver/Hepatitis/Liver Disease | ☐ | ☐ |
| Gall Bladder Disease/Cholelithiasis/Cholecystitis | ☐ | ☐ |
| Was stone in gall bladder or common bile duct? | ☐ | ☐ |
| Was it a single attack of symptoms? | ☐ | ☐ |
| Has the gall bladder been removed? | ☐ | ☐ |
| If YES, date surgery completed (MM/YYYY): | ____/_______ | |
| If NO, date of last attack of symptoms (MM/YYYY): | ____/_______ | |
| Has the applicant had Jaundice or Hepatitis in last 6 months? | ☐ | ☐ |
| Hernia | ☐ | ☐ |
| Inguinal, Scrotal, or Femoral hernia? | ☐ | ☐ |
| Has the hernia been operated on? | ☐ | ☐ |
| If NO, are there any symptoms from the condition? | ☐ | ☐ |
| If unoperated and symptomatic, are symptoms managed by medicine? | ☐ | ☐ |
| Colitis/Irritable Bowel Syndrome (IBS)/Spastic Colitis | ☐ | ☐ |
| Is the applicant currently under treatment for? | ☐ | ☐ |
| How many attacks have occurred? ☐ Single ☐ Multiple | | |
| If MULTIPLE, date of last episode (MM/YYYY): | ____/_______ | |
| Colon Polyps/Rectal Polyps | ☐ | ☐ |
| Are the polyps benign? | ☐ | ☐ |
| Are the polyps recurrent? | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ |
| Pancreatitis | ☐ | ☐ |
| Is the condition chronic? | ☐ | ☐ |
| Is there any history of alcohol abuse? | ☐ | ☐ |
| Is there any subsequent liver disease? | ☐ | ☐ |
| Was it only a single episode of pancreatitis? | ☐ | ☐ |
| Does applicant currently have pancreatitis? | ☐ | ☐ |
| If NO, date of last episode of symptoms (MM/YYYY): | ____/_______ | |
| Ulcerative Colitis/Chronic Inflammation of Colon | ☐ | ☐ |
| Other Digestive/Intestinal Disorder | ☐ | ☐ |

Please describe:

_______________________________________

_______________________________________

| | Yes | No |
|---|---|---|
| **8. Nervous System/Brain Disorder** | ☐ | ☐ |
| Which applicant(s) has a nervous system condition? ____________________ | | |
| Headaches/Migraines/Cluster Headaches | ☐ | ☐ |
| Severity and frequency of headaches (choose one): ☐ Mild (less than 3 per year) ☐ Moderate (3 to 6 per year) ☐ Severe (>6 per year) | | |
| How many visits to the ER for headaches over past two (2) years? ☐ 0 ☐ 1 ☐ 2 ☐ 3+ | | |
| Multiple Sclerosis | ☐ | ☐ |
| Polio | ☐ | ☐ |
| Does the applicant currently have? | ☐ | ☐ |
| If NO, has the applicant recovered from the condition? | ☐ | ☐ |
| Head Injury/Concussion | ☐ | ☐ |
| Was there a loss of consciousness? | ☐ | ☐ |
| If YES, how long was the loss of consciousness? | | |
| ☐ Less than 1 hour | | |
| If < 1 HOUR, any residual problems post recovery? | ☐ | ☐ |
| ☐ Less than 1 day | | |
| If < 1 DAY, date of recovery (MM/YYYY): ____/_______ | | |
| If < 1 DAY, any residual problems post recovery? | ☐ | ☐ |
| ☐ More than 1 day | | |
| Encephalitis/Encephalomyelitis | ☐ | ☐ |
| Does the applicant currently have this condition? | ☐ | ☐ |
| If NO, any residual complications post recovery? | ☐ | ☐ |
| If NO, date of recovery (MM/YYYY): ____/_______ | | |
| Alzheimer's Disease | ☐ | ☐ |
| Senility/Dementia | ☐ | ☐ |
| Heat Exhaustion/Heat Stroke | ☐ | ☐ |
| What condition did the applicant have (choose one): ☐ Heat Exhaustion ☐ Heat Stroke | | |
| Was this a single episode? | ☐ | ☐ |
| If NO, date of last episode (MM/YYYY): ____/_______ | | |
| Hydrocephalus | ☐ | ☐ |
| Narcolepsy | ☐ | ☐ |
| Neurofibromatosis | ☐ | ☐ |
| Neuroma/Abnormal Nerve Growth | ☐ | ☐ |
| Is the growth benign? | ☐ | ☐ |
| Has the applicant been operated on? | ☐ | ☐ |
| If YES, when was the surgery (MM/YYYY)? ____/_______ | | |
| If NO, when was the recovery (MM/YYYY)? ____/_______ | | |
| Is the diagnosis Morton's Neuroma? | ☐ | ☐ |
| ALS/Amyotrophic Lateral Sclerosis/Lou Gehrig's Disease | ☐ | ☐ |
| Autism | ☐ | ☐ |
| Cerebral Palsy | ☐ | ☐ |
| Paralysis/Hemiplegia/Paraplegia | ☐ | ☐ |
| Huntington's Chorea | ☐ | ☐ |
| Parkinson's Disease | ☐ | ☐ |
| Spina Bifida | ☐ | ☐ |
| Viral Meningitis | ☐ | ☐ |
| Bacterial Meningitis | ☐ | ☐ |
| Creutzfeldt-Jakob Disease | ☐ | ☐ |
| Muscular Dystrophy | ☐ | ☐ |
| Motor Neuron Disease | ☐ | ☐ |
| Myasthenia Gravis | ☐ | ☐ |
| Neuralgia/Neuritis | ☐ | ☐ |
| Other Disorder of the Nervous System | ☐ | ☐ |
| Please describe: ____________________ ____________________ | | |

| | Yes | No |
|---|---|---|
| **9. Mental or Nervous Condition/Depression** | ☐ | ☐ |
| Which applicant(s) has a mental health condition? ____________________ | | |
| Affective Disorders | ☐ | ☐ |
| What is the diagnosis (choose one below)? ☐ Panic Disorder ☐ Agoraphobia ☐ Anxiety Disorder ☐ Neuroses ☐ Obsessive Compulsive Disorder (OCD) | | |
| When was the applicant diagnosed (MM/YYYY)? ____/_______ | | |
| Is the treatment effective? | ☐ | ☐ |
| If YES, when was treatment effective (MM/YYYY)? ____/_______ | | |
| What is the severity of symptoms? ☐ Mild ☐ Moderate ☐ Severe | | |
| Schizophrenia | ☐ | ☐ |
| Paranoia | ☐ | ☐ |
| Major Depression/Bipolar Disorder | ☐ | ☐ |
| When was the diagnosis made (MM/YYYY)? ____/_______ | | |
| Eating Disorder/Bulimia/Anorexia | ☐ | ☐ |
| Does the applicant currently have an eating disorder? | ☐ | ☐ |
| If NO, when was the date of recovery (MM/YYYY)? ____/_______ | | |
| Attention Deficit Disorder/ADD/ADHD | ☐ | ☐ |
| What is the severity of symptoms? ☐ Mild ☐ Moderate ☐ Severe | | |
| Are symptoms controlled by medication? | ☐ | ☐ |
| Situational Depression/Mild Depression/Anxiety | ☐ | ☐ |
| Is prescription medication the only current treatment? | ☐ | ☐ |
| Other Mental Health/Psychiatric Disorders | ☐ | ☐ |
| Please describe: ____________________ ____________________ | | |

| | Yes | No |
|---|---|---|
| **10. Back or Neck Disorder** | ☐ | ☐ |
| Which applicant(s) has a back or neck condition? ____________________ | | |
| Cervical (Neck), Thoracic (Mid-Back), or Lumbar (Low-Back) Disc Herniation or Protrusion | ☐ | ☐ |
| Is the applicant currently under treatment for? | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ |
| If YES, was there any subsequent problems post-operation? | ☐ | ☐ |
| If YES, date of surgery (MM/YYYY): ____/_______ | | |
| If NO, has the applicant recovered? | ☐ | ☐ |
| If YES, date of recovery (MM/YYYY): ____/_______ | | |
| Is the applicant totally disabled due to their condition? | ☐ | ☐ |
| Low Back Pain | ☐ | ☐ |
| Is the applicant currently under treatment for this condition? | ☐ | ☐ |
| If NO, date of last episode (MM/YYYY): ____/_______ | | |
| Spinal Fractures | ☐ | ☐ |
| Are there any lingering neurological defects? | ☐ | ☐ |
| Is there numbness, tingling, pain, or paralysis | ☐ | ☐ |
| Was the fracture a compression fracture? | ☐ | ☐ |
| When was the last treatment (MM/YYYY)? ____/_______ | | |

**10. Back or Neck Disorder(Continued)** Yes ☐ No ☐

- Spinal Stenosis ☐ ☐
  - Has the applicant had surgery for this condition? ☐ ☐
    - If YES, give date of surgery (MM/YYYY): ____/_______
- Ankylosing Spondylitis/Spondylolisthesis ☐ ☐
  - Has the applicant had surgery for this condition? ☐ ☐
    - If NO, is the condition symptomatic? ☐ ☐
- Low Back Strain/Whiplash/Muscle Spasm ☐ ☐
  - Is the applicant currently under treatment for this condition? ☐ ☐
- Sciatica/Radiculitis/Radiating Pain to Legs or Arms ☐ ☐
  - Does the applicant have any neurological defects? ☐ ☐
  - Is applicant currently under treatment for? ☐ ☐
  - Are the episodes recurrent? ☐ ☐
  - When was the last episode (MM/YYYY)? ____/_______
- Spinal Deformities/Scoliosis/Lordosis ☐ ☐
  - Has the applicant had surgery for this condition? ☐ ☐
    - If YES, are there continuing problems post-operation? ☐ ☐
    - If YES, date of surgery (MM/YYYY): ____/_______
    - If NO, is the applicant currently under treatment? ☐ ☐
      - If YES, what is the severity of the condition? ☐ Mild/Moderate ☐ Severe
      - If NO, date of last treatment (MM/YYYY): ____/_______
- Spina Bifida/Myelocele ☐ ☐
  - Has the applicant had surgery for condition? ☐ ☐
    - If YES, is there any residual neurological defects? ☐ ☐
- Other Back/Neck Disorder ☐ ☐
  - Please describe: ________________________________________
    ________________________________________

**11. Muscular Disorder/Lupus** Yes ☐ No ☐

- Which applicant(s) has a muscular/connective tissue condition? _______________________________________________
- Collagen Diseases: Scleroderma/Ehlers-Danlos Syndrome/Mixed Connective Tissue Disease/Necrotizing Angiitis ☐ ☐
- Lupus Erythematosus ☐ ☐
- Fibromyalgia/Myitis/Myositis ☐ ☐
  - Is the applicant currently being treated for this condition? ☐ ☐
    - If NO, date of recovery (MM/YYYY): ____/_______
  - Are episodes recurrent? ☐ ☐
- Ligament Tears/Meniscus Tears/Osteochondritis ☐ ☐
- Dessicans/Chondromalacia ☐ ☐
  - Has the applicant had surgery for the condition? ☐ ☐
    - If YES, when was surgery completed (MM/YYYY)? ____/_______
- Muscle Tissue Abscess ☐ ☐
  - Cause of abscess? ☐ Trauma ☐ Disease ☐ Unknown
  - Is the applicant currently being treated for this condition? ☐ ☐
    - If NO, date treatment completed (MM/YYYY): ____/_______
- Polymyositis/Neuromyositis/Dermatomyositis ☐ ☐
- Other Muscular/Connective Tissue Disorder ☐ ☐
  - Please describe: ________________________________________
    ________________________________________

**12. Cancer/Tumors** Yes ☐ No ☐

- Which applicant(s) has cancer or a tumor? _______________________________________________
- Breast Cancer ☐ ☐
  - Is the cancer recurrent? ☐ ☐
  - Does the applicant know the staging of the tumor? ☐ ☐
    - If YES, what was the stage?
      ☐ Stage I ☐ Stage IIA ☐ Stage IIB
      ☐ Stage IIIA ☐ Stage IIIB ☐ Stage IV
  - Was the treatment surgery alone? ☐ ☐
  - Is the applicant under current treatment? ☐ ☐
    - If NO, date treatment completed (MM/YYYY): ____/_______
  - Is the cancer metastatic? ☐ ☐
  - Is the applicant under hospice care? ☐ ☐
- Lipoma/Adipose Tumor ☐ ☐
  - Was the tumor confirmed benign by biopsy? ☐ ☐
  - Has the tumor been removed? ☐ ☐
- Lymphoma/Hodgkin's Disease/Non-Hodgkin's Lymphoma ☐ ☐
- Melanoma ☐ ☐
- Lung Cancer ☐ ☐
- Basal Cell/Squamous Cell Skin Cancer ☐ ☐
  - Choose type of tumor: ☐ Basal Cell ☐ Squamous Cell
- Was tumor localized and include no lymph node involvement? ☐ ☐
  - Has there been any recurrence? ☐ ☐
  - Is the applicant under current treatment? ☐ ☐
    - If YES, what kind of treatment was done (choose one):
      ☐ Mohs Micrographic Surgery ☐ Radiation Therapy
      ☐ Simple Excision ☐ Carbon Dioxide Laser
      ☐ Electrodessication/Curettage ☐ Topical Fluorouracil
      ☐ Cryosurgery ☐ All Others
    - If NO, date treatment completed (MM/YYYY): ____/_______
- Ovarian Cancer ☐ ☐
- Prostate Cancer ☐ ☐
- Cervical Cancer ☐ ☐
- Colon/Rectal Cancer ☐ ☐
- Leukemia/Chronic Lymphocytic Leukemia (CLL)/Acute Lymphocytic Leukemia (ALL)/Chronic Myelogenous Leukemia (CML)/Acute Myeloid Leukemia (AML)/Acute Non-Lymphocytic Leukemia (ANLL), Lymphoma ☐ ☐
- Other Type of Cancer/Tumor: ☐ ☐
  - Please describe: ________________________________________
    ________________________________________

**13. HIV/AIDS/ARC** Yes ☐ No ☐

- Which applicant(s) has HIV, AIDS, or ARC? _______________________________________________

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **14. Epilepsy/Seizure Disorder** | ☐ | ☐ | | | |
| Which applicant(s) has epilepsy or a seizure disorder? | | | If YES, please describe condition: | | |
| ___________________________________ | | | ______________________________ | | |
| Seizure Disorder | ☐ | ☐ | Are seizures increasing in frequency? | ☐ | ☐ |
| Which disorder? | | | Is the applicant taking medications? | ☐ | ☐ |
| ☐ Seizure Disorder ☐ Epilepsy | | | If YES, are the seizures controlled by medication? | ☐ | ☐ |
| What type of seizure has been diagnosed? | | | When was the last seizure (MM/YYYY)? | ____/_______ | |
| ☐ Febrile ☐ Jacksonian | | | Other Seizure Disorder | ☐ | ☐ |
| ☐ Petit Mal ☐ Focal | | | Please describe: | | |
| ☐ Grand Mal ☐ Don't Know | | | ______________________________ | | |
| Is another disease condition causing seizures? | ☐ | ☐ | ______________________________ | | |

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **15. Drug or Alcohol Abuse** | ☐ | ☐ | | | |
| Which applicant(s) has a history of drugs or alcohol abuse? | | | | | |
| ___________________________________ | | | Is the applicant currently using? | ☐ | ☐ |
| What is the applicant dependent on? | | | If NO, when did the applicant last use (MM/YYYY)? | ____/_______ | |
| ☐ Alcohol ☐ Marijuana | | | | | |
| ☐ Other Drugs (besides marijuana and alcohol) | | | | | |

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **16. Urinary Tract/Kidney Disorder** | ☐ | ☐ | | | |
| Which applicant(s) has a kidney or urinary tract condition? | | | Does the applicant currently have this condition? | ☐ | ☐ |
| ___________________________________ | | | If NO, date of last episode (MM/YYYY): | ____/_______ | |
| Cystitis/Urinary Tract Infection (UTI)/Pyuria/Urethritis | ☐ | ☐ | How many episodes of symptoms have occurred? | | |
| Was this a single episode? | ☐ | ☐ | ☐ 1 ☐ 2 ☐ 3 ☐ 4+ | | |
| When was the last episode (MM/YYYY)? | ____/_______ | | Were stones in both kidneys? | ☐ | ☐ |
| Was there any protein/discharge/blood in urine? | ☐ | ☐ | Interstitial Cystitis | ☐ | ☐ |
| Cystic Disease of Kidneys | ☐ | ☐ | Does the applicant currently have? | ☐ | ☐ |
| Does the applicant have a solitary cyst? | ☐ | ☐ | If NO, date of last episode (MM/YYYY): | ____/_______ | |
| Does the applicant have polycystic kidneys? | ☐ | ☐ | Acute Renal Failure/Chronic Renal Failure | ☐ | ☐ |
| Has the applicant had surgery for this condition? | ☐ | ☐ | Other Kidney/Urinary Tract Disorder | ☐ | ☐ |
| If YES, date of surgery (MM/YYYY): | ____/_______ | | Please describe: | | |
| History of Kidney Transplant | ☐ | ☐ | ___________________________________ | | |
| Renal Calculi/Kidney Stones | ☐ | ☐ | ___________________________________ | | |

| | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| **17. Respiratory/Lung Disorder/TB/Allergies/Asthma** | ☐ | ☐ | | | |
| Which applicant(s) has a respiratory system condition? | | | Is the condition chronic? | ☐ | ☐ |
| ___________________________________ | | | Tuberculosis | ☐ | ☐ |
| Allergies/Asthma | ☐ | ☐ | Does the applicant currently have this condition? | ☐ | ☐ |
| Which of the following does the applicant have: | | | If NO, has the applicant recovered? | ☐ | ☐ |
| ☐ Allergies Only ☐ Asthma Only | | | Pulmonary Embolism/Pulmonary Infarction | ☐ | ☐ |
| ☐ Allergies and Asthma | | | Does the applicant know what caused Embolism/Infarction? | ☐ | ☐ |
| If ALLERGIES, is the applicant taking immunotherarpy shots? | ☐ | ☐ | If YES, please describe: | | |
| If YES, how often? | | | ______________________________ | | |
| ☐ Weekly ☐ Bi -Weekly | | | ______________________________ | | |
| ☐ Monthly ☐ Bi-Annually | | | Single episode of symptoms? | ☐ | ☐ |
| If ASTHMA, are attacks occasional or frequent? | | | Does the applicant have phlebitis-blood clots in legs? | ☐ | ☐ |
| ☐ Occasional ☐ Frequent | | | When did the symptoms last occur (MM/YYYY)? | ____/_______ | |
| If ASTHMA, how would you rate the applicant's condition? | | | Is the applicant continuing anticoagulant drug treatment? | ☐ | ☐ |
| ☐ Mild (Seasonal) ☐ Moderate ☐ Severe | | | Has the applicant fully recovered? | ☐ | ☐ |
| If ASTHMA, how long has the applicant had condition? | | | Dyspnea/Shortness of Breath | ☐ | ☐ |
| ☐ <2 Years ☐ 2-4 Years ☐ >4 Years | | | Is there an underlying condition causing Dyspnea? | ☐ | ☐ |
| If ASTHMA, has the applicant been hospitalized for condition? | ☐ | ☐ | If YES, please describe: | | |
| If ASTHMA, nebulizer used for acute episodes? | ☐ | ☐ | ______________________________ | | |
| If ASTHMA, is the applicant taking corticosteroids? | ☐ | ☐ | ______________________________ | | |
| If ASTHMA, is it controlled by medications? | ☐ | ☐ | Is the shortness of breath exercise-induced? | ☐ | ☐ |
| Bronchitis | ☐ | ☐ | If YES, how would the applicant characterize symptoms? | | |
| Have there been any hospitalizations for this condition? | ☐ | ☐ | ☐ Mild ☐ Moderate ☐ Severe | | |
| If YES, was there more than one hospitalization? | ☐ | ☐ | Other Respiratory Condition | ☐ | ☐ |
| Chronic Obstructive Lung Disease (COPD)/Emphysema | ☐ | ☐ | Please describe: | | |
| Sinusitis/Sinus Infection | ☐ | ☐ | ______________________________ | | |
| | | | ______________________________ | | |

## 18. Arthritis/Bone/Joint Disorder/TMJ ☐ Yes ☐ No

Which applicant(s) has an arthritis/bone/joint disorder and/or TMJ?

_____________________________________________

Arthritis ☐ Yes ☐ No

What type of arthritis does the applicant have?

☐ Degenerative ☐ Chronic Proliferative
☐ Hypertrophic ☐ Arthritis Deformans
☐ Senile ☐ Chondrocalcinosis
☐ Psoriatic ☐ Acute Infectious
☐ Sepitc ☐ Juvenile Rheumatoid
☐ Atrophic ☐ Adult Rheumatoid
☐ Osteoarthritis

Date of initial onset of symptoms (MM/YYYY): ____/_______

Is more than one joint affected? ☐ Yes ☐ No

If NO, is the joint a hip or knee? ☐ Yes ☐ No

Has the applicant had a hip/knee replacement? ☐ Yes ☐ No

If YES, date it was completed (MM/YYYY): ____/_______

Characterization of disease progression/degree of disability:

☐ Mild (Minimal) ☐ Moderate ☐ Severe

Is there a joint infection? ☐ Yes ☐ No

If YES, any bony involvement with infection? ☐ Yes ☐ No

If YES, is the applicant currently being treated? ☐ Yes ☐ No

If NO, when was the treatment completed (MM/YYYY)? ____/_______

Osteomyelitis/Bone Infection/Bone Abscess ☐ Yes ☐ No

Was there only a single episode of symptoms? ☐ Yes ☐ No

Bone/Joint involved in episode:

☐ Major Bone/Joint ☐ Minor Bone/Joint

Is the applicant currently under treatment for condition? ☐ Yes ☐ No

If NO, what date was treatment completed (MM/YYYY)? ____/_______

Bursitis/Tennis Elbow/Tendonitis/Synovitis ☐ Yes ☐ No

Was there only a single episode of symptoms? ☐ Yes ☐ No

Is the applicant currently under treatment for condition? ☐ Yes ☐ No

Carpel Tunnel Syndrome ☐ Yes ☐ No

Has the applicant had surgery for this condition? ☐ Yes ☐ No

Paget's Disease ☐ Yes ☐ No

Does the applicant have a single affected area? ☐ Yes ☐ No

Was the disease an incidental finding? ☐ Yes ☐ No

Ligament Tears/Torn Meniscus/Osteochondritis ☐ Yes ☐ No

Has the applicant had surgery for this condition? ☐ Yes ☐ No

If YES, date of surgery (MM/YYYY): ____/_______

Bone Dislocation ☐ Yes ☐ No

What type of dislocation (choose one)?

☐ Congenital Hip ☐ Patella (kneecap)
☐ Shoulder ☐ Knee (not kneecap)
☐ Hip (Traumatic) ☐ Other Joint (Traumatic)

Was there a single episode of symptoms? ☐ Yes ☐ No

Does the applicant currently have this condition? ☐ Yes ☐ No

Has the applicant had surgery on this condition? ☐ Yes ☐ No

Was the dislocation unilateral or bilateral?

☐ Unilateral ☐ Bilateral

Bone Fracture ☐ Yes ☐ No

Has the treatment been completed? ☐ Yes ☐ No

Has the applicant had surgery? ☐ Yes ☐ No

Was the fracture union or non-union?

☐ Union ☐ Non-Union

Where was the fracture? ☐ Yes ☐ No

☐ Leg/Hip/Foot ☐ Arm/Hand/Shoulder ☐ Other Bone

Rotator Cuff Tear ☐ Yes ☐ No

Has the applicant had surgery for this condition? ☐ Yes ☐ No

If YES, date of surgery (MM/YYYY): ____/_______

Date of original injury (MM/YYYY): ____/_______

Temporal Mandibular Joint (TMJ) ☐ Yes ☐ No

Does the applicant currently have this condition? ☐ Yes ☐ No

If NO, when did the applicant recover (MM/YYYY)? ____/_______

Osteoporosis ☐ Yes ☐ No

Is the underlying cause known for this condition? ☐ Yes ☐ No

If YES, please describe:

_____________________________________

_____________________________________

Are there any symptoms from this condition? ☐ Yes ☐ No

Have there been any subsequent fractures? ☐ Yes ☐ No

Does the applicant take steroids for this condition? ☐ Yes ☐ No

Gout/Gouty Arthritis/Hyperuricemia ☐ Yes ☐ No

How many attacks have occurred in the last (5) years?

☐ 1-2 ☐ 3+

Are the attacks controlled by medication and/or diet? ☐ Yes ☐ No

Other Bone/Joint Disorder ☐ Yes ☐ No

Please describe:

_____________________________________

_____________________________________

## 19. Other Illness, Disease, or Injury ☐ Yes ☐ No

Which applicant(s) has another type of disease, disorder, or injury?

_____________________________________________

Please describe other condition:

_____________________________________

_____________________________________

_____________________________________

_____________________________________

_____________________________________

## 20. Abnormal Laboratory Results ☐ Yes ☐ No

Which applicant(s) had abnormal laboratory results?

_____________________________________________

Please describe abnormal laboratory results:

_____________________________________

_____________________________________

| | Yes | No |
|---|---|---|
| **21. Hospitalization or Confinement for 10 Days or More** | ☐ | ☐ |

Which applicant(s) was hospitalized/confined for 10 days or more?

_______________________________________________

Please describe condition for hospitalization/confinement:

_______________________________________

_______________________________________

_______________________________________

_______________________________________

| | Yes | No |
|---|---|---|
| **22. Weight Gain/Loss of 15 or More Pounds in Past 12 Months** | ☐ | ☐ |

Which applicant(s) gained/lost more than 15 pounds in the past 12 months?

_______________________________________________

Please describe causes of weight gain/loss:

_______________________________________

_______________________________________

_______________________________________

_______________________________________

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