Individual Medical Questionnaire

ConnectiCare

I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until ConnectiCare Insurance Company, Inc. ("CICI") accepts and approves both this enrollment form and the employer application.

Employer: _____ **Employee ZIP code:** _____

1 Complete the following information for only those individual(s) requesting coverage, and indicate if anyone is covered by Medicare.

	Last name	First name	Date of birth	Gender	Medicare Part A or B
Employee					
Spouse					
Child 1					
Child 2					
Child 3					
Child 4					

2 Indicate if you, your spouse and any of your other listed dependents have been diagnosed in the past five (5) years or currently receive treatment and/or medication for any of the following conditions.

- ☐ Addison's Disease
- ☐ AIDS/HIV
- ☐ ALS/Lou Gehrig's Disease
- ☐ Alzheimer's Disease
- ☐ Ankylosing Spondylitis
- ☐ Autoimmune Disorder
- ☐ Autoimmune Hepatitis
- ☐ Bipolar Disorder (Manic Depression)
  - ☐ Managed by prescription medication
  - ☐ Inpatient stay over the past 12 months
- ☐ Cancer – not in remission
- ☐ Carcinoid Syndrome
- ☐ Cardiac Arrhythmia
- ☐ Cardiac Valve Insufficiency
- ☐ Cardiomyopathy
- ☐ Castleman Disease
- ☐ Chronic Immune Thrombocytopenia
- ☐ Chronic Inflammatory Demyelinating Polyneuropathy
- ☐ Chronic Renal Failure
- ☐ Chronic Wounds
- ☐ Cirrhosis of the Liver
- ☐ Congestive Heart Failure
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ Cystic Fibrosis
- ☐ Diabetes - Uncontrolled
- ☐ Emphysema
- ☐ Gaucher's Disease (or other lipid storage disease)
- ☐ Heart Attack/Myocardial Infarction
- ☐ Hemophilia
- ☐ Hepatitis B or C
- ☐ Hereditary Angioedema
- ☐ High Risk Pregnancy – History of
- ☐ Hypopituitarism
- ☐ Inflammatory Bowel Disease
- ☐ Ischemic Heart Disease
- ☐ Leukemia (current diagnosis)
- ☐ Major Depression
  - ☐ Managed by prescription medication
  - ☐ Inpatient stay over the past 12 months
- ☐ Multifocal Motor Neuropathy
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Myelodysplastic Syndrome
- ☐ Narcolepsy
- ☐ Neuromyelitis Optica
- ☐ Pancreatitis
- ☐ Paraplegia
- ☐ Parkinson's Disease
- ☐ Plaque Psoriasis
  - ☐ Managed by prescription medication
  - ☐ Managed by over the counter medication
- ☐ Psoriatic Arthritis
- ☐ Psychosis
- ☐ Pulmonary Fibrosis
- ☐ Pulmonary Hypertension
- ☐ Rheumatoid Arthritis (Juvenile/Adult)
- ☐ Sarcoidosis
- ☐ Seizure Disorders
- ☐ Sickle Cell Anemia
- ☐ Spina Bifida
- ☐ Spinal Stenosis
- ☐ Stroke – History of
- ☐ Substance Abuse
- ☐ Systemic Lupus
- ☐ Thalassemia Major
- ☐ Ulcerative Colitis
- ☐ Vasculitis
- ☐ Wegner's Granulomatosis

Additional Notes: Using the box below, please note recommended future treatment or diagnostic testing where applicable. Be sure to include the name of any medications you take for any noted condition checked above and any treatment details.

Print Clear Form

Certification: I hereby confirm that all answers on this form are full, complete and true to the best of my knowledge and belief. I understand that omissions, misrepresentations or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of reformation of coverage. I am duly authorized to execute this form and am employed full-time by the employer listed on the enrollment form. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, commits a fraudulent insurance act, punishable by penalties, imprisonment and restitution depending on applicable laws. I agree that my employer or its agent may send this enrollment form to CICI. I authorize all of my doctors, pharmacies, hospitals and other health care providers ("Providers") to give CICI any and all personal health information about me and others listed on this form. This authorization covers all health matters including those involving mental health, substance abuse and HIV/AIDS. I further authorize CICI to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of the authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

Employee's signature Date

Spouse's signature Date

Upon completion, enclose this form in an envelope, seal it, and return it to your employer.