



## Aetna Group Medical Questionnaire

Name of Prospect \_\_\_\_\_ Date Completed \_\_\_\_\_

Servicing Field Office \_\_\_\_\_ Contract State \_\_\_\_\_ Sales Consultant \_\_\_\_\_

**Plan Information**

Type of coverage Life \_\_\_ Medical \_\_\_ LTD \_\_\_

What types of medical plan options will be available:

HMO \_\_\_ QPOS \_\_\_ IMO \_\_\_ PPO \_\_\_ Other: please describe \_\_\_\_\_

**Prospective Group Information**

- |  |   |
|--|---|
| 1) Total number of eligible employees _____                    | 3) Current number of COBRA Continuees _____                                       |
| 2) Total number of employees to be included in this plan _____ | 4) Current number on Extension of Benefits (please attach copy of EOB page) _____ |

**Medical Profile**

Plan sponsor: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than \$25,000 been paid in the last 12 months?  Yes  No

B. Within the past 3 years, has any employee or dependent had a serious continuing claim (i.e., chronic or ongoing condition likely to cost \$10,000 or more per year for treatment) due to a mental or physical disorder?  Yes  NO If "Yes," check the appropriate box(es) below.

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> AIDS/Immune Disorders | <input type="checkbox"/> Cardiovascular       | <input type="checkbox"/> Intestines     | <input type="checkbox"/> Pancreas            |
| <input type="checkbox"/> Alcohol Abuse         | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Kidney         | <input type="checkbox"/> Skin                |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Drug/Substance Abuse | <input type="checkbox"/> Liver          | <input type="checkbox"/> Stomach             |
| <input type="checkbox"/> Back, Neck            | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Lungs          | <input type="checkbox"/> Stroke/Paralysis    |
| <input type="checkbox"/> Blood                 | <input type="checkbox"/> Ears/Eyes            | <input type="checkbox"/> Lupus          | <input type="checkbox"/> Venereal            |
| <input type="checkbox"/> Bone/Joint            | <input type="checkbox"/> Emphysema/Pulmonary  | <input type="checkbox"/> Mental/Nervous | <input type="checkbox"/> Other, Detail below |
| <input type="checkbox"/> Brain                 | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Migraines      |  |
| <input type="checkbox"/> Cancer/Tumor          | <input type="checkbox"/> Infertility          | <input type="checkbox"/> Neurological   |  |

C. Are any employees or dependents pregnant?  Yes  No If "Yes," how many? \_\_\_\_\_

If you answered "Yes" to question A or B, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	\$ Amount of Prior Claims	Prognosis / Current Treatment

The information on this form is designed to assist in Aetna US Healthcare's evaluation of your group. The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge.

Prospective Applicant Name and Title (Please Print)	Prospective Applicant Signature	Date
Agent Signature (Existing <input type="checkbox"/> Yes <input type="checkbox"/> No) Date	Sales Representative Signature	Date