EMPLOYEE MEDICAL QUESTIONNAIRE
FOR SMALL GROUP ENROLLMENT

QUESTIONS?
Call Customer Services:
(619) 228-2300 or
(800) 359-2002

Sharp Health Plan is committed to enhancing the health of all of its members. This questionnaire is designed to assist the Plan in developing appropriate levels of medical care. The information provided will not preclude you from coverage. Please list and answer questions for yourself and all family members who are applying for coverage with Sharp Health Plan. After completing form, remove the 3 strips of tape at bottom, then fold in half at score to seal for your privacy.

EMPLOYEE / FAMILY INFORMATION

	LAST NAME, FIRST, INITIAL	AGE	HEIGHT	WEIGHT
EMPLOYEE				
SPOUSE				
DEPENDENT				
DEPENDENT				
DEPENDENT				
DEPENDENT				

MEDICAL INFORMATION

ANSWER QUESTIONS FOR ALL PROPOSED INSURED AND PROVIDE DETAILS IN SPACE PROVIDED FOR ALL QUESTIONS ANSWERED "YES".

		YES	NO
1.	Has any **proposed insured**, within the past 5 years, been treated or examined for:		
a.	Heart attack, stroke, chest pain, or had heart surgery?		
b.	High blood pressure or any disorder of the blood or blood vessels?		
c.	Epilepsy, convulsions, depression, anxiety or any neurological disorder?		
d.	Asthma, allergies, emphysema or any disorder of the lungs or respiratory system?		
e.	Ulcer, colitis, or any disorder of the stomach, intestines, rectum, gallbladder, spleen, liver or pancreas?		
f.	Diabetes, sugar or albumin in the urine?		
g.	Cancer or any tumor or growth?		
h.	Kidney stones, kidney disorder, bladder, prostate or urinary system disorder?		
i.	Breast disorder or surgery; uterine disorder or any disorder of the reproductive organs?		
j.	Thyroid or other glandular disorder, or any disorder of the eyes, ears, nose or throat?		
k.	Arthritis, gout, rheumatism, back pains or any disorder of the bones, joints, spine or muscles?		
l.	Or been advised that he/she has AIDS or the AIDS related complex (ARC)?		
m.	Complications of pregnancy or a cesarean section?		
2.	Has any **proposed insured**, within the last 5 years: Used marijuana, cocaine, heroin, methamphetamines, or been advised to reduce alcohol intake?		
3.	Has/is any **proposed insured**:		
a.	Had an exam, checkup, or been treated by a doctor, chiropractor, psychiatrist, or psychologist for any reason within the last five years?		
b.	Been hospitalized in the past 5 years?		
c.	Currently taking medication prescribed by a doctor?		
d.	Or any family member (shown or not shown on this questionnaire) currently pregnant?		
4.	Does any **proposed insured** have any surgeries planned or recommended over the next 6 months or are you aware of any conditions that will require physician's care?		
5.	Has any **proposed insured** had a driver's license revoked, suspended, or been arrested for driving under the influence of alcohol? If yes, name of proposed insured and driver's license No.		

6a. Does any **proposed insured** smoke? ☐ yes ☐ no **6b.** How long?____________ **6c.** How many packs per day?____________

USE THIS SPACE FOR MEDICAL INFORMATION QUESTIONS ANSWERED "YES" ABOVE.

Question Number	Name of Family Member	Condition, injury, symptom of ill health, or findings of examination, prescription. If surgery performed, state type.	Month and Year	Duration	Result of Exam/Degree of Recovery	Name, address, zip and phone number of hospital and attending doctor

DISCLOSURE AND AUTHORIZATION

THIS AUTHORIZATION SECTION IS TO BE SIGNED BY THE ELIGIBLE EMPLOYEE AND SPOUSE APPLYING FOR COVERAGE.

I agree: That all the information in this questionnaire is correct and true to the best of my knowledge.
I understand that California law prohibits an HIV test from being required/used by health care plans as a condition of obtaining coverage.
I understand that my employer's application will determine the coverages in force and that coverage is not in force if an application for that coverage has not been made by my employer and approved by Sharp Health Plan.
I, the applicant, acknowledge that I have read and understand this questionnaire in its entirety.

Employee Name (Please Print) Social Security No.

X

Employee Signature Date

PLEASE RETURN TO YOUR COMPANY BENEFITS REPRESENTATIVE

CONFIDENTIAL INFORMATION!
FORWARD TO THE ABOVE
WITHOUT BREAKING SEAL!