

### Preexisting Condition Inquiry Form

Employee Name: _____	Employee SSN: _____
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Your benefit plan contains a Pre-Existing Condition Limitation. In order to properly administer your benefit plan we need additional information from you. Failure to complete this form at time of enrollment may result in the delay or denial of claim payment.

NOTE: This information will NOT be used for any purpose prohibited by law.

Please check one:

I am now eligible for coverage and had no previous coverage during the past 90 days.

I am now eligible for coverage and had previous coverage during the past 90 days.

Name of previous carrier: \_\_\_\_\_ Plan # \_\_\_\_\_ Coverage Eff Date: \_\_\_\_\_ Coverage Term Date: \_\_\_\_\_  
Attach Credible Coverage Certificate from your previous Health Care Carrier.

Answer each question by checking the "Yes" or "No" line, as it applies. If "Yes" is checked, provide details below.

During the past 6 months have you, or any dependent to be covered, had, been diagnosed as having, or been treated for:

	Yes	No
1. a. Alcoholism, Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>
b. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
c. Back or Neck Disorder, Injury or Pain	<input type="checkbox"/>	<input type="checkbox"/>
d. Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
e. Cancer or Tumors	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
g. Gastro or Intestinal Disorder	<input type="checkbox"/>	<input type="checkbox"/>
h. Heart Disorder or Condition or Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
i. High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
j. Kidney or Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>
k. Lung or Respiratory Disorder	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental or Nervous Disorder	<input type="checkbox"/>	<input type="checkbox"/>
m. Paralysis, Stroke or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you or any dependent to be covered been diagnosed by a member of the medical profession as having AIDS or HIV +(positive)?	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past six (6) months have you or any dependent to be covered:		
a. been examined or treated by a physician or other health care provider for any condition, illness or injury, other than as stated above?	<input type="checkbox"/>	<input type="checkbox"/>
b. Been advised to have treatment or surgery or testing that has not been done?	<input type="checkbox"/>	<input type="checkbox"/>
c. been admitted to a hospital or other health care facility as an inpatient?	<input type="checkbox"/>	<input type="checkbox"/>
d. taken prescribed medication(s)?	<input type="checkbox"/>	<input type="checkbox"/>
e. used tobacco products?	<input type="checkbox"/>	<input type="checkbox"/>

Please give details for any "Yes" answers to any parts of questions 1, 2 or 3. Attach a separate sheet if more space is needed for answers. The separate sheet should be signed and dated.

Question #/letter	Name of Person	Condition	Duration of Symptoms, Treatment Degree of Recovery	Date	Name and Address of Hospital and Practitioners

I verify that the above information is true and accurate: \_\_\_\_\_  
Signature and Date