



**PRESCRIPTION DRUG RIDER
HEALTH QUESTIONNAIRE**

For Office Use Only:

Member # _____ Premium: _____
Rep _____ Payment: ACH Coupon E-Pay
Date Sent to Membership: ___/___/___ YT
Coverage Effective Date ___/___/2010 HP
Accept Decline UW: _____ Date: ___/___/___

Select Rx Plan (One Rx plan must be chosen to prevent a delay in your application process)

Rx 1000 **Rx 3000**

Policyholder: _____

Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Home Phone : (_____) _____ - _____ Alternate Phone: (_____) _____ - _____

Please list all applicants that are currently a member on your plan.

| | | | |
|---------------------|----------|----------------------------|-----------|
| Policyholder: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |
| Spouse: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |
| Dependent: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |
| Dependent: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |
| Dependent: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |
| Dependent: _____ | Sex: M F | Date of Birth: ___/___/___ | Age _____ |

IMPORTANT

The information listed below is correct to the best extent of my knowledge. I understand that failure to provide true and correct information may jeopardize my Health Plan coverage, if approved. The following questions must be answered in reference to **all applicants** applying for coverage.

1. Has anyone had a medication prescribed which they are no longer taking or been advised by a physician to start a medication and not yet done so? **Yes** **No** If **“Yes”**, Please give medication and explanation: _____

2. Is anyone currently taking or taken **any** medications in the last two years. **Yes** **No**
If **“Yes”**, please list in the **Medication Table** on page 2.

