



For Office Use Only:

Member # _____ Premium: _____
 Rep _____ Payment: ACH Coupon E-Pay
 Date Sent to Membership: ___/___/___
 Coverage Effective Date: 11 / 1 / 2011
 Accept / Decline Date: ___/___/2011
 Underwriter: _____

**PRESCRIPTION DRUG RIDER
HEALTH QUESTIONNAIRE**

Application to Add Engage 3000 Prescription Drug Coverage

Applications for prescription drug coverage are subject to medical review; prescription drug coverage is not guaranteed.

Policyholder (First Last Name): _____ Date of Birth: ___/___/___

Billing Address: _____ Apt # _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

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 to them in the last 24 months which they are no longer taking? ___ **Yes** ___ **No**

If **“Yes”**, Please give the name of medication(s) and explanation: _____

2. Has anyone been advised by a physician to start a medication and not done so? ___ **Yes** ___ **No**

If **“Yes”**, Please give medication and explanation: _____

3. 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.

Medication Table Please fill in each column, using NA if not applicable.

Name of Applicant	Prescribing Physician	Name of Drug	Strength (e.g.:50mg tablet)	Dosage/Frequency				Date Started				Date Stopped			
				Number Taken		Re-fill Information									
				Day	Mo	Qty per fill	No. fills per year								
Sample-John	Jane Smith	Zoloft	.50	2		60	12	0	3	9	9	1	2	0	6

I understand that prescription drug coverage in the Scott & White Health Plan is not automatic, and that the information provided by me is material to the issuance of prescription coverage, and therefore state that the information provided is true, correct and complete. Without regard to any intention to deceive, incorrect or incomplete information may at the Scott & White Health Plan's option, void my prescription coverage and that of any dependents from the date of the issuance of the certificate. If I become aware of any requested information that should be corrected or made complete prior to the Scott & White Health Plan's acceptance of this application, I will inform the Scott & White Health Plan or my coverage will be void from the date of issuance.

If my application for Scott & White Health Plan prescription coverage is denied, I understand only Scott & White Health Plan Underwriting Department employees will explain the basis for denial. I must submit questions, in writing to Scott & White Health Plan Underwriting Department, using the information that will be given in the prescription coverage denial letter.

Date: _____ By: _____
 (Signature of Applicant or Guardian, if applicant is a Minor)

Fraud Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.