



PRESCRIPTION DRUG RIDER HEALTH QUESTIONNAIRE

For Office Use Only:

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

Action:
[] Adding RX [] Changing To A Different Rx Plan
[] Health Plus Rx 1000 [] Health Plus Rx 3000 [] Engage Rx 3000 (This plan requires that you change your medical coverage from the Health Plus product to the Engage products.)

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? ___ 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.

