

Part II Health History and Medical Questionnaire

The following questions should be answered in reference to **all applicants**. Do you have or has anyone applying on this application had any of the following conditions. For any question you mark “Yes”, please explain in Part III, including beginning and ending dates regarding any condition.

<p>A. Non-correctable eye problems, cataracts, glaucoma, frequent stuffy or watery nose, sneezing and allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>P. Hallucinations, trouble falling asleep/staying asleep; feel tired after a good night’s sleep; feel depressed, feel like crying without reason; eating disorder; have trouble with nervousness, schizophrenia, or other psychosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>B. Asthma or wheezing, frequent cough, shortness of breath, coughing up blood, TB, repeated night sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Q. Any alcohol usage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list beverages and number of ounces per week in Part III, Columns A, B and F.</p>
<p>C. High blood pressure, high cholesterol/lipids, heart disease, pacemaker, artificial heart valve, varicose veins, chest pain or heavy pressure with exertion, leg pain from walking rapidly or up hill, fast heartbeat or skipping beats, rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>R. Narcotics or illegal drugs currently being used or used within the last 4 years, including marijuana? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in Part III, Columns A, B and F.</p>
<p>D. Any skin problems, difficulty swallowing, abdominal pain, hernia, frequent indigestion or heartburn, constipation, diarrhea or frequent bowel changes, ulcer, bleeding problems including rectal or gastrointestinal, black or tarry bowel movements, yellow jaundice, hepatitis, liver problems, pancreas problems, positive test for hepatitis B or C, gallstones, gallbladder problems, any stomach or intestinal problems, blood in your vomit, anemia, blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>S. Tested positive on an AIDS / HIV related blood test, been treated for, or diagnosed as having acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>T. Exercise regularly? <input type="checkbox"/> Yes <input type="checkbox"/> No What type of exercise? If yes, please provide answers in Part III, Columns A, B and F.</p>
<p>E. Venereal disease, such as gonorrhea, syphilis, herpes, pelvic inflammatory disease, chlamydia, etc. <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>U. Been advised to have surgery or treatment that you have not yet undergone? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>F. Cancer/lymphoma/leukemia?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>V. Has anyone ever applied for or received Worker’s Compensation or disability benefits?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in Part III, Columns A, B and F.</p>
<p>G. Ever had “abnormal” results to blood test; urinalysis; blood pressure or basal metabolism; X-ray or EKG? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>W. Ever been rejected by the armed services for health reasons, denied a pilots license for health reasons, denied a policy of coverage by any health insurance company or life insurance company; offered a policy of coverage by a health insurance company or life insurance company different from the coverage applied for or at a higher premium rate (rated up)? ... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in Part III, Columns A, B and F.</p>
<p>I. Has anyone ever had any surgery, serious illness or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>X. Check any hobbies: <input type="checkbox"/> Skydiving <input type="checkbox"/> None <input type="checkbox"/> Motor Vehicle Racing <input type="checkbox"/> Aviation <input type="checkbox"/> Bungee Jumping <input type="checkbox"/> Scuba Diving <input type="checkbox"/> Snake Hunting <input type="checkbox"/> Rodeo Riding <input type="checkbox"/> Mountain Rock Climbing If any checked, please explain in Part III, Columns A, B and F.</p>
<p>J. Used tobacco products of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No What was used? How long was it used? When did usage stop (month/year)? Please provide answers in Part III, Columns A, B and F.</p>	<p>Y. (Men only) Experienced any prostate problems, infertility problems or impotence? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>K. Regularly exposed to any chemical toxins, fumes, smoke, or radioactive materials? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Z. Question for Female applicants only over the age of 12. Z1. Vaginal bleeding between periods, vaginal bleeding following the stopping of your menstrual periods (menopause), endometriosis, fibroid polycystic breasts, lump in breast? Treated for infertility, currently pregnant, pregnancy complication? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain in Part III, Columns A, B and F. Z2. Date of last menstrual period. Please answer in Part III, Columns A, B, and F. Place date in Column F. Was it normal?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain in Part III, Columns A, B and F. Z3. List date of last Pap smear. Please answer in Part III, Columns A, B and F. Place date in Column F. Pap results normal? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain in Part III, Columns A, B and F.</p>
<p>L. Has weight changed by more than 20 pounds in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No How many pounds? Up or Down? If yes, please provide answers in Part III, Columns A, B and F.</p>	
<p>M. Problems with urinary tract, kidneys, or bladder; kidney stones; loss of urine control; urinary retention or insufficiency; pain or burning when urinating; blood, albumin, protein, pus, sugar in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of last kidney stones? If yes, please provide answers in Part III, Columns A, B and F.</p>	
<p>N. Diabetes, thyroid disease, goiter, pituitary or adrenal disorders or weight problem? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>O. Broken bones, frequent back/neck pain, pain or swelling around joints, arthritis, gout, rheumatism, pain, popping or locking of jaw? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Part IV Certification and Authorization for records release.

This enrollment application must be updated to include any change in health status or impairment, which occurs between the date of application and the date of becoming a member. Failure to provide this information to the Scott & White Health Plan will constitute a misrepresentation of the presence of a pre-existing impairment or disease that will void your coverage when discovered.

I understand that coverage with Scott & White Health Plan is not automatic. The information provided by me on this application is used by Scott & White Health Plan and is material to its decision to either, accept or decline my coverage. I therefore certify that the information that I have provided is truthful, complete, and made to the best of my knowledge and belief. I acknowledge that any incorrect or incomplete information contained in this application may cause Scott & White Health Plan to void my coverage, if it is determined, that had this information been disclosed on the application, the Scott & White Health Plan would have declined my coverage. If I become aware of any requested information that should be corrected or made complete prior to Scott & White Health Plan's acceptance of this application, or at any time in the future, I will inform Scott & White Health Plan or my coverage will be voided from the date of issuance.

Further, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, or other organization, institution, or person, that has any records or knowledge of me or my family's health, to give to the Scott and White Health Plan any such information that it may request if permitted by law, including but not limited to any information pertaining to psychiatry/psychology, drug/alcohol usage, and HIV/AIDS. I understand that my authorized disclosure of protected health information carries with it the potential for re-disclosure and may no longer be protected by the Federal privacy laws. I understand that I may revoke this authorization in writing at any time, except to the extent that Scott & White Health Plan or any health care provider has already relied on this authorization. I understand that I may revoke this authorization by providing Scott & White Health Plan with a written request for revocation stating my intent to revoke this authorization. This authorization expires 12 months from the date the authorization is signed. Scott & White Health Plan may deny you enrollment or eligibility for benefits if you fail to complete this authorization form.

I understand that Scott & White Health Plan may not have conducted a review of my medical records or obtained copies of my records from all of my doctors, clinics, and other health facilities. To the extent allowed by law, if Scott & White Health Plan later finds evidence of a medical condition which I did not list on this form and which could legally be used to deny coverage, the Scott & White Health Plan will terminate my coverage. I understand that in the absence of complete medical records, a general physical may be required and will be at the applicant's expense.

Upon decision, I will receive notification by mail. If the application has been approved, the initial monthly premium payment must be paid in advance prior to the issuance of an agreement. The notification will include premium amount and deadline for remittance.

I understand that medical information acquired by Scott & White Health Plan is confidential and protected by law. Scott & White Health Plan however, may make a brief report thereon to MIB (Medical Information Bureau), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB member company for life or health insurance coverage, or a claim filed for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. In this regard, I understand that Scott & White Health Plan employees are not allowed to reveal Scott & White Health Plan's basis for approval or denial, outside of the MIB membership rules, of my application unless Scott & White Health Plan is required to reveal that basis through legal process. Scott & White Health Plan will not approve or deny my application on any basis which is prohibited by law.

If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. You may also contact MIB by telephone at 866-692-6901. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file.

I hereby certify that to the best of my knowledge the answers given are current, truthful, and complete.

A photographic copy of this authorization shall be as valid as the original.

Signed at _____ this _____ day of _____, 20____
(City) (State) (# day) (Month) (Year)

Print Name of Primary Applicant

Signature of Primary Applicant

Print Name of Spouse (if applying)

Signature of Spouse (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)

Print Name of Dependent (if applying)

Signature of Parent or Guardian of Dependent (if applying)