Group Health Questionnaire

Group Name: ____

1. Do you know of any employee or dependent that is:

   a. Currently pregnant or have reason to suspect you might be pregnant? YES☐ NO☐

   b. Financially responsible for an unborn child, anticipating adoption, applying for, or have applied for adoption? YES☐ NO☐

2. Do you know of any employee or dependent that, in the past 24 months, has been recommended to have, or been scheduled for, diagnostic testing, treatment, or surgery that has not been completed? YES☐ NO☐

3. Do you know of any employee or dependent that, within the past 24 months, has had a health related condition for which they have not sought medical advice or treatment? YES☐ NO☐

4. Do you know of any employee or dependent that, within the past five years, has received any abnormal test results, medical or surgical treatment, healthcare professional consultation, or prescribed medication for any of the following conditions? (Check all that apply.)

☐ a. Arthritis, Reumatologic disorder or any disease or disorder of the joints, bones, muscles or back
☐ b. AIDS or tested positive for HIV
☐ c. Asthma, Emphysema, COPD, TB, or any other disease or disorder of the respiratory system
☐ d. Cardiovascular disease or disorder of the heart , arteries, blood vessels or blood
☐ e. Cancer or tumor
☐ f. Chemical dependency, drug or alcohol abuse, or any other mental health disease or disorder
☐ g. Crohn's disease, ulcerative colitis, hepatitis or any other disorder of the liver, stomach, colon, or intestines
☐ h. Diabetes or any other disorder of the pancreas
☐ i. Immune system disease or disorder
☐ j. Kidney disease or disorder
☐ k. Neurological system disorder
☐ l. Stroke

If you answered yes to any of the questions or checked off any of the health conditions above, please explain, including any expected future treatment or medications. (If you are filling out a printed form you may use the back of the sheet for your explanations.)

Name of Person	Date of Incident/ Last Treatment	Explain Condition	Explain Treatment

I certify that the above information is true to the best of my knowledge. I understand that this may become part of an application for health insurance and is subject to the Utah code regarding such applications.

Signature: ______________________________ Date: ________________

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