ASSURANT
Health®

Enrollment Packet—Washington State

Use this enrollment packet for individual medical applicants in the state of Washington. Please follow the instructions below to ensure the quickest processing.

Provide the following items to your clients:

- Paper Enrollment Packet (Form 29937, which includes Forms 29932 and 30300-WA). Your clients should review the rates, verify the benefits selected and complete a Standard Health Questionnaire (SHQ) for each necessary family member.
- Appropriate Outline of Coverage.
- Prescription Drug Disclosure (Form 30039), if necessary.

Mail these items to Assurant Health:

- Paper Enrollment Packet (Form 29937, which includes Forms 29932 and 30300-WA), approved by your client.
- Standard Health Questionnaire (SHQ), with one SHQ filled out by each family member applying for coverage. One SHQ is included in this Enrollment Packet. You may download additional copies from Find a Form at www.assuranthealthsales.com.

Please list any family members exempt from completing the SHQ.

____

____

____

All documents are available on Find a Form at www.assuranthealthsales.com. Just search for Form 29937 to download the entire application packet.

MAIL ALL DOCUMENTS TO:

Assurant Health
501 W. Michigan St.
PO Box 692
Milwaukee, WI 53201-0692

For agent use only. Not for distribution to consumers.
Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.
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Quote Form — Washington State
Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

CALCULATING A RATE

1. Use the medical premium tables that correspond to the plan selected.
2. Find the primary insured rate for the plan selected and effective date desired. Enter it on the "Primary Insured" line below.
3. If the quote includes a spouse, find the spouse's age and rate according to the effective date desired. Enter the rate below on the "Spouse" line.
4. If there are dependent children, find the child rate for the appropriate effective date and enter the rate below on the "Child" line. Multiply the rate times the number of children to get the total monthly child rate.
5. Add all results together to get the total monthly premium for medical.

PREMIUM QUOTE EXAMPLE

Plan ID: 059	Desired Effective Date: 10/1/2010		Washington ZIP Code: 99327
Primary Insured:	Age: 30	Smoker Status: Yes ☐ No ✓	Medical $69.64
Spouse:	Age: 25	Smoker Status: Yes ☐ No ✓	Medical $60.67
Child:	Medical $38.89 x 2		Medical $77.78
Subtotal for Medical:			Medical $208.09
Optional Dental Vision ($9.95) Yes ✓ No ☐			$9.95
TOTAL MONTHLY PREMIUM:			**$218.04**

PREMIUM QUOTE

Plan ID:	Desired Effective Date:		Washington ZIP Code:
Primary Insured:	Age:	Smoker Status: Yes ☐ No ☐	Medical $
Spouse:	Age:	Smoker Status: Yes ☐ No ☐	Medical $
Child:	Medical: $_ _._ _ x __ =		Medical $
Subtotal for Medical:			Medical $
Optional Dental Vision ($9.95) Yes ☐ No ☐			$
TOTAL MONTHLY PREMIUM:			**$**

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Washington State Benefit Proposal Form
Medical Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

AGENT & PRIMARY PROPOSED INSURED INFORMATION

This is a supplemental Plan Selection form. Submit this form along with Washington Enrollment Form 30300-WA.
Please complete the Agent and Primary Proposed Insured information below as it appears on Enrollment Form 30300-WA.

Agent Name: ______________________________

Agent Number: ______________________________

Name of Primary Proposed Insured: ______________________________

To be eligible for the plans listed below, each Applicant must meet the underwriting criteria based on completion of the Washington State Standard Health Questionnaire (if required).

Outlines of Coverage summarizing the main benefits, exclusions and limitations are available for each of the plans listed below and will be provided at your request. Once you have selected a plan as part of this application, an Outline of Coverage specifying the coverage type and benefit levels you choose will be provided.

MEDICAL PLAN OPTIONS

Choose the Plan. Then select from the choices of in-network Individual Deductible, Coinsurance Rate and Out-of-Pocket Amount available for the plan. Deductible is included in the Total Out-of-Pocket Amount shown. Family amounts are two times the individual amounts shown. Then enter the rate for the plan selected.

☐ **Washington Catastrophic Plans** ***(Non-HSA compatible)***

- ☐ $2,000 deductible; 25% coinsurance; total out-of-pocket of $4,500
- ☐ $2,000 deductible; 25% coinsurance; total out-of-pocket of $7,000
- ☐ $3,000 deductible; 25% coinsurance; total out-of-pocket of $5,500
- ☐ $3,000 deductible; 25% coinsurance; total out-of-pocket of $8,000
- ☐ $5,000 deductible; 25% coinsurance; total out-of-pocket of $10,000
- ☐ $5,000 deductible; 50% coinsurance; total out-of-pocket of $15,000
- ☐ $10,000 deductible; 50% coinsurance; total out-of-pocket of $20,000

☐ **Washington HSA Qualified Plan**

This plan is only available with a $2,700 in-network Individual Deductible ($5,400 Family).
You pay in-network 20% coinsurance. Total Individual Out-of-Pocket maximum is $4,700 ($9,400 Family).

☐ **Washington Comprehensive Plan** ***(Non-HSA compatible)***

This plan is only available with a $1,500 in-network Individual Deductible ($3,000 Family).
You play in-network 25% coinsurance. Total Individual Out-of-Pocket maximum is $9,000 ($18,000 Family).

***NOTE:** *If you later decide to change to another individual medical health plan, the period of time you are covered under a **Catastrophic Health Plan** may not be credited towards the new health plan's pre-existing condition waiting period.*

Assurant Health 501 West Michigan Milwaukee, WI 53201
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Washington State Enrollment Form for Medical and/or Prescription Insurance for Individuals and Families

PLEASE PRINT IN BLACK INK

INSURANCE PRODUCER/AGENCY INFORMATION

Insurance Producer Name: ______________________________

Insurance Producer Number: ______________________________

Key Agency Contact: ______________________________

Fax Number: ______________________________

Phone Number: ______________________________

E-mail Address: ______________________________

Agency Name: ______________________________

Agency Number: ______________________________

Sales Rep Number: ______________________________

TYPE OF ACTIVITY *(Please check appropriate boxes.)*

☐ **NEW ENROLLMENT APPLICATION** Requested effective date: ______________________________(month) ☐ 1st ☐ 15th
(The requested date cannot be more than 60 days after the completed enrollment forms are received.)

If we receive complete enrollment materials by the 20th of the month, approved coverage can be effective as early as the 1st of the following month. If we receive complete enrollment materials by the 31st of the month, approved coverage can be effective as early as the 15th of the following month. Check with your insurance producer for more details.

If not a new enrollee, check the appropriate box and list the affected policy number.

☐ **CHANGE/ADDITION TO AN EXISTING POLICY. POLICY #** ______________________________

☐ Internal Replacement
☐ Adding Dependent
☐ Removal of Tobacco Rates
☐ Conversion (over age dependent/divorce)
☐ Policy/Benefit Change to an Existing Policy *List Type Of Change Requested:* ____________________
☐ Reinstatement of Coverage

PERSON(S) TO BE INSURED

Attach a separate sheet, signed and dated, if additional space is needed for other dependent children.

	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	Tobacco use within the past 12 months? *Yes* *No*	Social Security Number
1. PRIMARY					☐ ☐	
2. SPOUSE/STATE REGISTERED DOMESTIC PARTNER					☐ ☐	

3. DEPENDENTS *(list relationship)*	Name *Last* *First* *MI*	Sex	Age	Birthdate *(MM/DD/YY)*	Social Security Number
a.					
b.					
c.					
d.					
e.					

4. Resident Address: ____
(NO P.O. BOXES) *(Street)* *(City)* *(State)* *(ZIP)*

5. County of Residence: ____

I represent that I am a resident of Washington State and that my permanent home and place of habitation is within Washington State for purposes other than obtaining insurance. . . . . ☐ Yes ☐ No

6. Mailing Address: ____
(If different than resident address) (Street) (City) (State) (ZIP)

7. Daytime Number: (_____) ____________________ 8. E-mail Address: ____________________

9a. Are any of the proposed insureds covered by any type of medical insurance in the past 63 days? .... ☐ Yes (Complete section 9b) ☐ No (Go to question 10)

9b. *Attach a separate sheet, signed and dated, if additional space is needed for other dependent children.*

Proposed Insured	Insurance Company Name	Group or Individual	Type of Coverage*	Deductible	Effective Date *(MM/DD/YY)*	Termination Date *(MM/DD/YY)*	Is this coverage being replaced by proposed coverage?
Primary							
Spouse/State Registered Domestic Partner							
Dependent a.							
Dependent b.							
Dependent c.							
Dependent d.							
Dependent e.							

*For example, major medical, hospital surgical, WSHIP, or cancer.

10a. Are any of the proposed insureds eligible for Medicare? *(If yes, complete question 10b.)* .... ☐ Yes ☐ No

10b. Name(s) ____

BILLING

☐ **Monthly Electronic Funds Transfer (EFT)/Check-O-Matic (COM)**

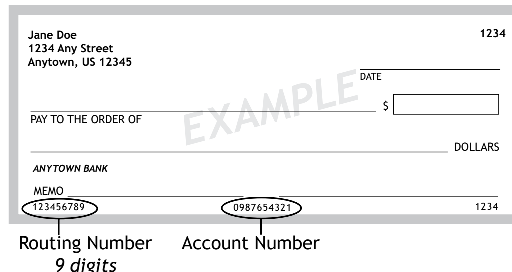
☐ **To begin withdrawals:**
The initial draft will occur on the day your coverage is approved. Subsequent drafts will occur on the same day of the month as your effective date.

Bank name: ______________________________

City: ____________________ State: ______________

Routing number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Account number: ______________________________



Routing Number
9 digits
Account Number

☐ **To add this policy to an existing Electronic Funds Transfer (EFT)/Check-O-Matic (COM):**

Existing EFT/COM number: ______________________________

Associated policy number: ______________________________

Electronic Funds Transfer (EFT)/Check-O-Matic (COM) *(Complete authorization below)*

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, indicated on the other side, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it

______________________________ ______________________________
Accountholder Signature Date Signed

☐ **Bill me directly:** Choose how often: ☐ Quarterly ☐ Semi-Annual ☐ Annual

If your billing address is different than your home address, please enter it here:

Billing Address: ____
(Street) (City) (State) (ZIP)

Name of person paying, if different: ______________________________

☐ **List bill (monthly only)** Employer Name ____________List Bill Acct. # ____________

Note: List bill must be set up prior to this selection.

STANDARD HEALTH QUESTIONNAIRE EXCEPTIONS & WAIVER DOCUMENTS

11. Do any of the following exceptions apply to any person(s) to be insured?.........☐ Yes ☐ No
    If yes, please indicate [☑] which person(s) and exception(s) apply.

	Primary	Spouse	Enter dependent information in same order as page 1. a.	b.	c.	d.	e.
12. You changed residences from one part of Washington state to another part where your current health plan is not offered, <u>and</u> you are submitting your application within 90 days of relocation. ***(A copy of your utility bill with the prior address dated within 90 days of the date of this application is needed for proof)***	☐	☐	☐	☐	☐	☐	☐
13. Your health care provider is no longer part of the provider network on your current individual health plan and a. Your health care provider is on the new health plan you are applying for; and b. You received services from that provider during the 12 months before he or she left your current health plan; and c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network. ***(A letter of verification from the provider or insurer is needed for proof)***	☐	☐	☐	☐	☐	☐	☐
14. You are applying for individual health coverage within 90 days of using up your COBRA coverage. (this includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.) You must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium. ***(A Certificate of Creditable Coverage and a letter from the employer indicating type and dates of coverage is needed for proof.)***	☐	☐	☐	☐	☐	☐	☐
15. You have been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event? ***(A Certificate of Creditable Coverage and a letter from the employer indicating type and dates of coverage is needed for proof.)***	☐	☐	☐	☐	☐	☐	☐
16. You are applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination. ***(A Certificate of Creditable Coverage and a letter from the employer indicating type and dates of coverage is needed for proof.)***	☐	☐	☐	☐	☐	☐	☐
17. You are applying for individual health coverage within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event buy you choose not to take COBRA coverage. ***(A Certificate of Creditable Coverage and a letter from the employer indicating type and dates of coverage is needed for proof.)***	☐	☐	☐	☐	☐	☐	☐
18. You have been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment. ***(A letter or coverage certificate from the Washington State BHP indicating dates of coverage is needed for proof)***	☐	☐	☐	☐	☐	☐	☐
19. You are adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days. ***(A copy of adoption/placement papers is needed for proof)***	☐	☐	☐	☐	☐	☐	☐

STANDARD HEALTH QUESTIONNAIRE EXCEPTIONS & WAIVER DOCUMENTS *(continued)*

If any of the exceptions apply, you must provide proof as specified above (for each person(s) to be insured). A Standard Health Questionnaire is not required for any person(s) who meet(s) one or more of the exceptions listed above to be insured under an individual health benefit plan.

Note: Regardless if any of the above exceptions apply, if you are applying for the Select 5000 outpatient prescription drug plan, a complete Standard Health Questionnaire must be submitted for purposes of underwriting the Select 5000 outpatient prescription drug plan. A determination by Time Insurance Company that you are not eligible for the outpatient prescription drug plan based on your Standard Health Questionnaire does not constitute an entitlement right to the Washington State Health Insurance Pool.

HIPAA ELIGIBILITY

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), certain individuals have a guaranteed right to an individual plan without a pre-existing exclusion. In order for Time Insurance Company to determine whether you or anyone applying for coverage is entitled to such a plan, please review the following and indicate whether ALL of the following statements are true at the time you or anyone to be insured apply for individual coverage:

- You have at least 18 months of continuous creditable coverage without any break in coverage greater than 63 days.
- Your most recent coverage was under a group plan, a governmental plan or a church plan.
- You are not covered under another group health plan.
- Your most recent coverage was not cancelled because you did not pay premiums or because you committed fraud.
- You are not currently eligible for Medicare or Medicaid.
- You have exhausted any continuation of coverage (COBRA or state continuation) for which you were eligible.

☐ **No, I or anyone to be insured do not meet one or more of the above requirements.**

☐ **Yes, I or anyone to be insured meet all of the above requirements. (A Certificate of Creditable Coverage is needed for proof.)**

EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

You understand and agree that you are applying for individual health insurance for you (and your family). You further understand that this application for health insurance will be fully medically underwritten based on your responses to the Washington Standard Health Questionnaire and to other eligibility requirements permitted under Washington laws, and that coverage is not guaranteed . You are personally paying the entire premium for this health insurance coverage. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

Do you agree with this statement? . . . . ☐ Yes ☐ No

HEALTH SAVINGS ACCOUNT (HSA) SERVICES

If you are applying for an HSA plan, please select one of the following HSA Account Services:

☐ HSA Tools
☐ Other

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Will this insurance replace any other accident and sickness insurance presently in force? ☐ Yes ☐ No, (If yes, see below.)

According to your statement you intend to terminate existing accident and sickness insurance and replace it with a new policy to be issued by TIME INSURANCE COMPANY. For your own protection, you should seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions*) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

   ** In most circumstances if you are replacing an Individual Medical policy issued by Time Insurance with another Individual Medical policy issued by Time Insurance without a gap in coverage, the pre-existing conditional limitation and any waiting periods will not start over.*

2. You may wish to seek the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. **If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

   *** This does not apply to Guaranteed Conversions applying for same/similar coverage.*

AUTHORIZATION

My enrollment form, and any amendments including but not limited to my complete and accurate Standard Health Questionnaire, if required, shall be the basis for the contract.

I understand the insurance coverage(s) is subject to underwriting. The insurance, if approved by Time Insurance Company, will be in force only when issued by Time Insurance Company. The first full premium must be paid. Coverage(s) will become effective on the later of: A) The requested effective date; or, B) the 1st of the following month if completed enrollment materials are received by the 15th of the month; or, C) the 15th of the following month if completed enrollment materials are received by the 31st of the month. A change in the health of the proposed insured(s) after the completion of the enrollment form and/or Washington Standard Health Questionnaire and before the delivery of the contract may affect my eligibility for insurance with the company. I understand and agree that any information I provide through this application process may be shared with persons necessary to facilitate issuing coverage, including but not limited to my insurance producer. If any of these conditions are not met, Time Insurance Company has the right to rescind and/or terminate its offer of coverage(s) and the full extent of its liability shall be limited to the sum received.

I agree that a photocopy of this authorization shall be valid for two years from the date signed.

I understand that the following authorizations are required in order to enable Time Insurance Company to verify representations made on the Standard Health Questionnaire in the investigation of fraud, or to determine a pre-existing condition relating to me, and/or my minor children, during the course of my medical or other coverage requested in this application. This authorization is used in the investigation of claims submitted and not during the underwriting process for medical coverage, although claims experience already on file with the company may be used at the time of underwriting to verify accuracy of representations on the Standard Health Questionnaire. If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.

I hereby authorize any health care provider or medically related facility, pharmacy, pharmacy benefit manager or pharmacy related facility, consumer reporting agency, insurance or reinsurance company or employer having information about me or my minor children to provide all such information including information regarding employment, other insurance coverage, personal information, medical or pharmacy care, advice, treatment, or medication use as may be requested to Time Insurance Company, its legal representative or any medical records retrieval service Time Insurance Company may engage, including, but not limited to, Examination Management Services, Inc.(EMSI).

This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, prescription history, lab data and EKGs.

I further authorize Time Insurance Company to disclose any and all such information to any medical records company engaged by Time Insurance Company, including but not limited to EMSI and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, P.O. Box 3050, Milwaukee, WI 53201-3050. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.

Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: denial of my application, declination of enrollment, or, if insured, when I am no longer an insured of Time Insurance Company.

I acknowledge receiving the notification regarding the Abbreviated Notice of Insurance Information Practices and the Outline(s) of Coverage for the insurance for which I am applying.

I acknowledge that I have read the completed enrollment form. I attest that all statements and answers on this enrollment form and the Washington Standard Health Questionnaire (if required) are complete, true and correct. I understand and acknowledge that any fraudulent statement or material misrepresentation or omission on the enrollment form, recorded Authorizations, personal health history and/or any amendments may result in claim denial or contract(s) rescission and/or termination, subject to the time limit on certain defenses or incontestability provisions of the contract(s).

This enrollment form and the completed Standard Health Questionnaire (if required) may be used for purposes of underwriting the individual health benefit plan including a determination of eligibility for the Washington State Health Insurance Pool and/or underwriting any outpatient prescription drug plan for which I am applying. I understand that in regard to any outpatient prescription drug plan, the Standard Health Questionnaire is for underwriting purposes only. I acknowledge that a determination by Time Insurance Company that I am not eligible for the outpatient prescription drug plan based on my Standard Health Questionnaire does not constitute an entitlement right to the Washington State Health Insurance Pool. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

____

Signature of Primary Proposed Insured

____

Signature of Spouse/State Registered Domestic Partner
(if proposed to be insured)

____

Signature(s) of Other Dependent(s) 18 or Over
(if proposed to be insured)

____

Guardian's Signature *(if primary proposed insured is a minor)*

Premium Amount Sent $ ______________________________

______________ A.M./P.M. ______________

Date &Time signed **City & State signed in**

Attention: (Insurance Producer)

I have reviewed this enrollment form to ensure that all required items have been completed.

To the best of my knowledge, there ☐ **IS** ☐ **IS NOT** a replacement of medical insurance involved in this transaction.

____

Licensed Resident Insurance Producer's Signature

____

Print Insurance Producer's Name

__________ Initial here if you witnessed the signing of this form by the proposed insured.

IMPORTANT NOTICES — LEAVE WITH CUSTOMER

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.

FRAUD NOTICE

It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or insurance producer of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds, shall be reported to the Division of Insurance within the Department of Regulatory Agencies.

PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration, and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

Will this insurance replace any other accident and sickness insurance presently in force? ☐ Yes ☐ No, (If yes, see below.)

According to your statement you intend to terminate existing accident and sickness insurance and replace it with a new policy to be issued by TIME INSURANCE COMPANY. For your own protection, you should seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have, (pre-existing conditions*) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

   ** In most circumstances if you are replacing an Individual Medical policy issued by Time Insurance with another Individual Medical policy issued by Time Insurance without a gap in coverage, the pre-existing conditional limitation and any waiting periods will not start over.*

2. You may wish to seek the advice of your present insurer or its insurance producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3. **If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

   *** This does not apply to Guaranteed Conversions applying for same/similar coverage.*

The above "Notice to Appliant" was delivered to me on: ______________________________
(Date)

____
(Applicant's Signature)

STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Use for Individual Coverage Beginning On or After October 1, 2009
Revised for coverage beginning on or after June 10, 2010

Important Information Before You Start

- Washington law allows private health carriers to require a person applying for an individual policy to complete the attached Standard Health Questionnaire and requires persons applying for nonsubsidized enrollment in the Basic Health Plan to complete the questionnaire if they do not qualify for an exemption. For purposes of this questionnaire subsequent references to "health carrier" include the Health Care Authority when administering the nonsubsidized Basic Health Plan.
- Under some circumstances **you may be exempt from taking the questionnaire**. (See page 2.)
- The Standard Health Questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is the only health screening allowed by law for health carriers to use if they wish to screen for health conditions as a part of their determination of eligibility of people who apply for private, individual medical coverage.
- **Those rejected for medical coverage due to their score on the Standard Health Questionnaire are eligible for WSHIP coverage**. WSHIP was created by the Washington State Legislature to provide health coverage to those rejected for individual medical coverage or to those unable to obtain comprehensive coverage on either an individual or group basis.
- Health carriers may use the Standard Health Questionnaire as a health screening tool for products such as stand-alone prescription drug plans, disability income replacement or life insurance policies sold by the health carrier. Use of the Standard Health Questionnaire for these kinds of products does not guarantee the right to coverage with the Washington State Health Insurance Pool if an applicant is denied coverage for one of these products.
- The Standard Health Questionnaire is available from private health carriers on **paper** as a part of their application packet **or electronically for those applying for coverage on-line**.

Attention: If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage; and you should not fill out this questionnaire. **Medicare** is a federally sponsored program for individuals age 65 or older, or who have end-stage renal disease, or are disabled as defined by Social Security. Medicare and **Medicaid** are different. Medicaid is a state-sponsored program for individuals and families who qualify based on income and other criteria.

Need Help in Answering this Questionnaire?

- *Contact the **health carrier** that you are submitting your application to; or*
- *Contact your **insurance agent**; or if you do not have an agent, use the **WSHIP Agent Directory** to locate an agent who is knowledgeable about the questionnaire. Request a copy of the Agent list from the health carrier to whom you are applying, or go to **www.wship.org***

ARE YOU EXEMPT FROM TAKING THIS QUESTIONNAIRE?

Revised for coverage beginning on or after June 10, 2010

Answer the following questions before you fill out the questionnaire *to determine if you meet one of these exemptions.*

If you do not know the answer *to a question,* ***do not fill out this questionnaire****. Please contact your agent or health carrier to whom you are applying for further instructions.* You may be asked to provide further documentation to support your responses to the following questions.

If you answer "Yes" *to any of the following questions,* ***do not complete the health questionnaire.*** You may apply to the health carrier without taking the questionnaire.

If you answer "No" *to all of the following questions****, this page must be completed along with Parts 2 and 3 of the questionnaire.*** *Submit the completed questionnaire to the health carrier with your application.*

Question	Yes	No
1. **Have you changed residences from one part of Washington state to another part where your current health plan is not offered, and you are submitting your application within 90 days of relocation?**	○	○
2. **Is your health care provider no longer part of the provider network on your current individual health plan?** To answer yes, all of the following must be true: a. Your health care provider is on the new health plan you are applying for; and b. You received services from that provider during the 12 months before he or she left your current health plan; and c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network.	○	○
3. **Are you applying for individual health coverage within 90 days of using up your COBRA* coverage?** (This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.) To answer yes, you must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium.	○	○
4. **Have you been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event?**	○	○
5. **Are you applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination?** (Not applicable to BHP applicants.)	○	○
6. **Are you applying for individual health coverage within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event but you choose not to take COBRA coverage?** (Not applicable to BHP applicants.)	○	○
7. **Have you been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment?**	○	○
8. **Are you adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days?**	○	○
9. **Are you applying for individual insurance 90 days before or after your employer discontinues your group insurance due to business closure and you had at least 24 months of continuous group insurance coverage immediately prior to your insurance being discontinued and the effective date of the individual insurance you are applying for is on or within 90 days after the date your group insurance is discontinued?**	○	○

* COBRA refers to the federal law that requires certain employers to continue health coverage temporarily for certain former employees, retirees, spouses and dependents, at their expense when coverage is lost due to certain specific events. For more information about COBRA rules, go to the U.S. Dept. of Labor website: http://www.dol.gov/ebsa/faqs

PART 1.
INFORMATION ABOUT THE STANDARD HEALTH QUESTIONNAIRE

Submitting Your Questionnaire

- If you are applying for family coverage, **a separate questionnaire must be completed for each family member**.
- **Do not send medical records with this questionnaire**. If you are rejected for coverage and appeal the rejection, the health carrier may request further medical information which you may choose to provide if you believe it will assist the carrier in correctly scoring your questionnaire.
- If you have had health coverage from the health carrier to whom you are now applying for individual coverage, as part of reviewing your questionnaire the health carrier may also review the medical information in its files dating from your prior coverage with the health carrier.
- Any time you apply for individual coverage, change from one health carrier to another, or change plans with your current health carrier, a current health questionnaire may be required unless you are exempt from taking the questionnaire (see exemptions list page 2).
- **Your signed questionnaire will be valid to accompany your application for coverage for a 90 day period from the date you sign it**. If you wait more than 90 days to submit your application, you may have to complete a new health questionnaire.

How Your Questionnaire Is Scored

- The health carrier uses a standard scoring system designed by WSHIP to score your questionnaire.
- The scoring system document can be obtained from your health carrier or agent, or viewed and printed from WSHIP's website, www.wship.org.
- **Questions about the scoring of your questionnaire must be directed to the health carrier you are applying with, or your insurance agent, but not to WSHIP**.

If You Are Denied Coverage Because of Your Score

- If the health carrier rejects your application because of your score **you must be sent a rejection notice within 15 business days** after the health carrier **received** your completed application and health questionnaire. To be "complete" this questionnaire must be signed and dated. You must fully and completely answer every question.
- The health carrier will mail you information about coverage available through WSHIP. Your insurance agent can also provide this information to you, or you can contact WSHIP toll-free at 1-800-877-5187, or at www.wship.org. **To be eligible for WSHIP you must apply for coverage within 90 days of the date you receive your notice of rejection from the health carrier**.
- You may request an appeal of your score.

How To Appeal Your Score To the Health Carrier

You may request a review of your score if you think the health carrier did not score your questionnaire correctly or did not respond within the required time frame.

- To request a review of your score, **contact the health carrier directly in writing within 45 days of receipt of your rejection notice. Do not contact WSHIP to appeal your score.**
- **You may apply for coverage with WSHIP** during the time that your appeal is under review. (Contact WSHIP at 1-800-877-5187 for assistance.)

How To Appeal Your Score To WSHIP

- If the health carrier does not complete its review of your appeal within 30 calendar days of their receipt of your appeal request, or if you have exhausted your appeal rights with the health carrier, you may request a review from WSHIP.
- **WSHIP's review is limited** to whether the health carrier correctly applied the scoring system for the questionnaire and whether the health carrier's notice of rejection for coverage was provided or postmarked within 15 business days of the health carrier's receipt of your completed application.
- Send your written request for review to WSHIP along with:
  1. A copy of your completed health questionnaire;
  2. The health carrier's score of your questionnaire;
  3. A copy of your written appeal request to the health carrier; and
  4. A copy of the health carrier's written denial of your appeal, if applicable.
- **Mail to**: Appeals, WSHIP, P.O. Box 1090, Great Bend, KS 67530. For assistance call WSHIP toll-free at 1-800-877-5187.
- Within five business days of receipt of your request, WSHIP will respond to you confirming receipt of your request, the date it was received, the nature of the complaint and the resolution requested.
- WSHIP will investigate your appeal and make its decision within 30 days of receipt of the complete information needed to respond to the appeal. WSHIP will notify you and the health carrier of its decision. If you do not agree with the results of this appeal, you may appeal to the WSHIP Grievance Committee.
- **Contact WSHIP if you wish to enroll with WSHIP during your appeal review period.**

Your Privacy Rights

By completing this form, you are giving your medical information to the health carrier. Under Washington State RCW 48.43.021, except as otherwise required by statute or rule, a health carrier and the Washington State Health Insurance Pool (WSHIP), and persons acting at the direction of or on behalf of a health carrier or WSHIP, shall not disclose an applicant's personally identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. Each health carrier issues its own "consumer privacy statement" and maintains its own privacy policies.

PART 2. QUESTIONNAIRE

Instructions

1. ***Fill in your name*** *and other information in the box below.*
2. ***Read the definitions*** *(next page) to help you understand the questions.*
3. *In each section,* ***answer the YES/NO question in the box at the top of the page*** *to the best of your ability. Review the conditions in the table below the YES/NO question before answering.*
4. ***If you answer NO, you can move on to the next section.***
5. ***If you answer YES, fill in the circle(s) next to each numbered medical condition you have or had within the stated time period.*** *Mark all conditions you have or had. This includes any conditions which resulted from another primary diagnosis. For example, for cancers that have metastasized, mark all types of cancer for which you have been diagnosed, treated, medicated and/or monitored. If you have multiple instances of a single condition you only need to mark it once.*
6. ***If you do not find your condition*** *listed on the questionnaire,* ***you can search for it on WSHIP's website****, under the link "Guide to Marking Medical Conditions on the Standard Health Questionnaire"* ***or you can write down this condition in Section L*** *of the questionnaire. Some rare medical conditions are not included in the questionnaire; however, they may be scored. A list of rare conditions can be obtained from the health carrier you are applying to or from the Office of Rare Disease Research* http://rarediseases.info.nih.gov/RareDiseaseList.aspx*; or from WSHIP's website, www.wship.org.*
7. *In answering this questionnaire, you are protected by federal law from having to reveal any information about your family history or any experience with genetic testing, genetic counseling, or other genetic services not related to diseases you currently have.*
8. *If you are the* ***parent or guardian*** *who is filling out this questionnaire for a child or individual with disabilities, please answer the questions as if "you" means the child or disabled individual; and check the box at the bottom of the signature page.*
9. ***Sign*** *and write the* ***date signed*** *on the last page.*

IMPORTANT: *Do not say you have a condition* ***unless*** *a doctor or other licensed medical care provider told you that you have or had a condition.* ***Be sure to mark all of the conditions you have or had.***

Your height and weight will be used in scoring to determine if you have morbid obesity.

ABOUT YOU – YOU MUST FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF:

First Name ______ M.I. ___ Last Name ______

Date of Birth __ / __ / ____ Contact Phone Number (___) ___ – ____ Height: Feet __ Inches __ Weight: Pounds ___

Mailing Address ______ City ______ State ___ Zip ______

Email Address (optional, if you wish us to use it to contact you) ______

Gender ○ Male ○ Female

Definitions

The following is a **list of terms** used in this questionnaire. These definitions will help you fill out the questionnaire if you do not understand any terms used.

- **Acute** (as opposed to **Chronic**)**:** An illness typically with a sudden onset and resolving after a single course of treatment or therapy. Many are infectious in origin. Examples include pneumonia, gastritis, urinary tract infection, and minor trauma not requiring surgery.

- **Benign** (as opposed to **Malignant**)**:** A mild and non-progressive form of a disease.

- **Chronic** (as opposed to **Acute**)**:** A continuing illness that may or may not improve over time. Chronic illnesses can last from weeks to years. Examples include heart failure, COPD, leukemia, and many of the psychiatric illnesses such as depression and schizophrenia.

- **Congenital:** A condition that existed at birth. This condition may be inherited or may have developed in the womb. Although the condition existed at birth it may not be discovered until later in life.

- **Diagnosed:** A licensed physician or medical professional has identified a specific disease or medical condition.

- **Malignant** (as opposed to **Benign**)**:** A severe and progressively worsening form of a disease.

- **Medicated:** A drug prescribed by a licensed physician or other licensed medical professional has been taken for the treatment of a medical (including mental) condition.

- **Monitored:** A licensed medical professional has assessed the state of an existing or previously diagnosed disease or condition, possibly including diagnostic tests or imaging. A specific condition must first be diagnosed to be monitored. Monitoring does not include routine preventive screenings that are recommended for the general population in the absence of disease such as annual mammograms for women.

- **Physical Trauma:** An injury to any tissue by physical or chemical means. This may include abrasions, lacerations, incisions, or stab, puncture, or bullet wounds. When trauma occurs to the bone, this can result in fractures, dislocations, or sprains. Trauma can also be the result of exposure to toxic chemicals, high heat, irradiation, or electrical shock causing damage to tissues and organs.

- **Treated:** A licensed physician or other licensed medical professional has recommended a course of action or performed services to remedy a disease. For example, having surgery and having a diet and exercise program developed by a physician are both forms of treatment.

Section A. Certain High-Scoring Medical Conditions

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the last 5 years? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) within the last 5 years.*

○ No *If NO, complete Sections B through L.*

Section A. Certain High-Scoring Medical Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had) in the last 5 years*
1	AIDS	○
2	HIV sero-positive without AIDS	○
3	Amyotrophic lateral sclerosis (Lou Gehrig's disease)	○
4	Autism - Severe: minimal and inappropriate interaction with others, repetitive or restrictive behaviors (hand flapping, head rolling, self injury), limited or no speech, frequently requiring placement into a special education setting	○
5	Bilateral (left and right) leg amputation	○
6	Biliary atresia (congenital blockage of bile duct)	○
7	Brain or spinal cord abscess	○
8	Brain injury resulting in a deep or prolonged coma	○
9	Central nervous system (brain or spinal cord) malformation prior to birth (prenatal in origin)	○
10	Cerebral palsy	○
11	Cervical spina bifida	○
12	Cirrhosis of the liver	○
13	Cretinism	○
14	Cystic fibrosis	○
15	Fetal damage resulting from medication or substance usage (example: fetal alcohol syndrome)	○
16	Fragile X syndrome	○
17	Hemophilia	○
18	Huntington's Chorea	○
19	Inflammatory bowel disease (e.g. Crohn's disease, ulcerative colitis)	○
20	Leukemia	○
21	Lymphoma (examples: Hodgkin's disease, multiple myeloma, non-Hodgkin's lymphoma, reticulosarcoma)	○
22	MRSA (methicillin resistant staph) infection of internal organs other than the lungs	○

TABLE CONTINUED ON NEXT PAGE

Section A. Certain High-Scoring Medical Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had) in the last 5 years*
23	Mucopolysaccharidoses (example: Hunter's syndrome)	○
24	Multiple sclerosis	○
25	Muscular Dystrophies (examples: Duchenne, Pompe)	○
26	Myelodysplastic syndromes (examples: pancytopenia, aplastic anemia)	○
27	Necrotizing fasciitis (example: flesh eating bacterial infection)	○
28	Nephrotic syndrome	○
29	Organ transplant except cornea	○
30	Peritonitis (example: inflammation or infection of intestinal lining)	○
31	Pulmonary heart disease	○
32	Rheumatic heart disease – with complications (heart valve damage, anemia)	○
33	Severe Burns on more than 50% of one's body	○
34	Spinal trauma **with** surgery completed or recommended in the future or **with** paralysis (examples: fracture of the lumbar vertebrae, closed fracture of dorsal vertebra)	○
35	Subdural hematoma (blood clot on the brain) – **with** complications (loss of speech, sight, memory; paralysis)	○
36	Wegener's granulomatosis	○

- *If you answered YES to Section A, you may choose to answer each Section B through L, or you may skip to Part 3.*
- *If you answered NO to Section A, complete Sections B through L.*

Section B. Cancer or Benign Tumors

Cancer (malignancy) develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells. Sometimes these cells form tumors, which are abnormal growths of body tissues. Not all tumors are cancerous. **Benign tumors can also be referred to as cysts, polyps, or dysplasia.**

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section B. Cancer or Benign Tumor(s):			
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *For cancer, mark all sites including secondary cancers (metastasis).*		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
37	Adrenal – cancer		○
38	Bone and connective tissue – cancer (examples: bone metastases, gastrointestinal stromal tumors, leg sarcoma)		○
39	Bone and connective tissue – benign tumor (example: foot cyst)	○	
40	Breast – cancer **with** chemotherapy or radiation therapy completed or recommended in the future (examples: ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS))		○
41	Breast – cancer **without** chemotherapy or radiation therapy completed or recommended		○
42	Breast – benign tumor (examples: breast calcium deposits, breast duct papilloma, breast fibrocystic disease, breast fibroids, gynecomastia)	○	
43	Central nervous system – cancer, primary (examples: brain cancer, spinal cord cancer)		○
44	Central nervous system – cancer metastases (secondary cancer)		○
45	Central nervous system – benign tumor (examples: acoustic neuroma, benign meningioma, pineal gland cyst)		○
46	Ear/nose/throat/mouth – cancer (examples: cancer of the mouth, larynx cancer, pharynx cancer)		○
47	Ear/nose/throat/mouth – benign tumor (example: nasal polyp)	○	
48	Eye, external – cancer (examples: canthus cancer, carcinoma of the eyelid)	○	
49	Eye, external – benign tumor	○	
50	Eye, internal – cancer		○
51	Female reproductive system (uterus, cervix, or ovaries) – cancer **with** chemotherapy or radiation therapy completed or recommended in the future		○
52	Female reproductive system (uterus, cervix, or ovaries) – cancer **without** chemotherapy or radiation therapy completed or recommended		○
53	Female reproductive system (uterus, cervix, or ovaries) – benign tumor (examples: cervical dysplasia, endometrial hyperplasia, uterine fibroid)	○	
54	Genitourinary – cancer except prostate **with** chemotherapy or radiation therapy completed or recommended in the future (examples: bladder cancer, kidney cancer, renal carcinoma, testicular cancer)		○

TABLE CONTINUED ON NEXT PAGE

Section B. Cancer or Benign Tumor(s):			
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *For cancer, mark all sites including secondary cancers (metastasis).*		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
55	Genitourinary – cancer except prostate **without** chemotherapy or radiation therapy completed or recommended		○
56	Intestinal or rectal cancer – cancer (examples: carcinoid tumor, colon cancer)		○
57	Liver – cancer including liver metastases		○
58	Pancreas – cancer		○
59	Peripheral nerve – cancer (example: neurofibromatosis)		○
60	Pituitary gland – cancer		○
61	Pituitary gland – benign tumor **with** acromegaly (gigantism), pituitary dwarfism, or diabetes insipidus		○
62	Pituitary gland – other benign tumors (examples: high prolactin levels, hyperprolactinemia, prolactinoma)		○
63	Prostate – cancer **with** chemotherapy or radiation therapy completed or recommended in the future		○
64	Prostate – cancer **without** chemotherapy or radiation therapy completed or recommended		○
65	Prostate – benign tumor (example: benign prostatic hypertrophy and/or hyperplasia (BPH))		○
66	Pulmonary system – cancer (examples: lung and bronchial cancer, lung metastases)		○
67	Pulmonary system – benign tumor (example: lung cyst)		○
68	Skin – cancer **with** chemotherapy or radiation therapy completed or recommended in the future (example: melanoma)		○
69	Skin – cancer **without** chemotherapy or radiation therapy completed or recommended		○
70	Stomach and esophageal – cancer		○
71	Thyroid and parathyroid – cancer		○
72	Other benign tumors (examples: abdomen, adrenal gland, anus, back cyst, basal cell growth, colon polyp, cystadenoma of the pancreas, esophagus, eye-internal, fatty tumor, genitourinary system, hyperplastic polyp, intestines, perianal cyst, parotid gland, pseudopapillary tumor of the pancreas, rectum, rectal cyst, seborrheic keratosis, skin, Zollinger-Ellison syndrome)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section C. Circulatory, Blood or Heart Conditions

Our vascular system is made up of blood vessels, which are part of our circulatory or cardiovascular system that works with the beating heart. With each beat, the heart pumps blood into the vessels and throughout the body, providing nutrients and oxygen to cells. The circulating blood removes waste products, toxins and other harmful substances. Our circulatory system is critical to many body functions, especially our respiratory or lung function, digestion, waste removal and body temperature. Medical conditions can occur when these systems are not working properly.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section C. Circulatory, Blood or Heart Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
73	Agranulocytosis (examples: leukocytopenia, neutropenia)		○
74	Anemia of chronic diseases (anemia with a chronic disease such as diabetes or kidney failure) (mark chronic disease as well)		○
75	Anemia – iron deficiency	○	
76	Anemia – sickle-cell		○
77	Aortic aneurysm (balloon-like weakened area) (example: stomach aortic aneurysm)		○
78	Arterial aneurysm, except aorta (example: subclavian arterial aneurysm)	○	
79	Arterial diseases – non-inflammatory (examples: abnormal connections between arteries and veins, abnormal narrowing of the arteries, fistulas, hereditary hemorrhagic telangiectasia, renal hyperplasia)	○	
80	Atherosclerosis (hardening of the arteries due to a build up of plaques)		○
81	Atrial fibrillation and flutter – **with** surgery completed or recommended in the future		○
82	Atrial fibrillation and flutter – **without** surgery completed or recommended		○
83	Cardiac – congenital disorders (examples: congenital heart block, congenital insufficiency of aortic valve, Ebstein's anomaly, ostium secundum type atrial septal defect, pulmonary stenosis, ventricular septal defect)		○
84	Cardiac – infection (examples: endocarditis, myocarditis, pericarditis)	○	
85	Cardiomyopathy		○
86	Conduction disorders – severe ventricular rhythms (examples: Long QT syndrome, ventricular fibrillation)		○
87	Conduction disorders – mild including severe heart block (examples: abnormal heartbeat – fast, slow or irregular heart rhythm, arrhythmia, atrioventricular (AV) block, bundle branch block, dysrhythmia, tachycardia, sick sinus syndrome)		○
88	Congestive heart failure		○

TABLE CONTINUED ON NEXT PAGE

Section C. Circulatory, Blood or Heart Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
89	Embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of veins (examples: blood clots in the veins, deep vein thrombosis, venous stasis ulcers)	○	
90	Embolism – pulmonary	○	
91	Hematological diseases (examples: lymphadenitis, pernicious or other anemias, thalassemia)	○	
92	Hepatitis A or B (including viral hepatitis)		○
93	Hepatitis C		○
94	High blood pressure (hypertension) – benign		○
95	High blood pressure (hypertension) – malignant (hypertension resulting in damage to a major organs like the kidneys or eye) – **with** complications including kidney failure or congestive heart disease (mark complications as well)		○
96	High blood pressure (hypertension) – malignant (hypertension resulting in damage to a major organs like the kidneys or eye) – **without** complications		○
97	High cholesterol (examples: hyperlipidemia, hyperglyceridemia)		○
98	Ischemic heart disease – **with** angioplasty (balloon and/or stent), cardiac catheterization, or valve surgery (coronary artery bypass surgery or CABG) completed or recommended in the future (examples: angina, **coronary artery disease**, coronary atherosclerosis, **heart attack**, myocardial infarction, pectoris, ventricular hypertrophy)		○
99	Ischemic heart disease – **without** surgery completed or recommended		○
100	Lipidoses – unable to process fats (examples: Fabry's disease, Gaucher's disease, Krabbe disease, Mucolipidosis I-III, Niemann-Pick disease, Refsum's disease, Tay-Sachs disease, Wolman's disease)		○
101	Lymphatic channels disorders (example: noninfectious lymphedema)	○	
102	Thrombocytopenia (abnormally low platelets in blood)		○
103	Valvular disorder (examples: aortic valve disorders, mitral valve disorders)		○
104	Other circulatory conditions (examples: arteriovenous malformation, arteritis, inflammation of the veins, palpitations, phlebitis, Raynaud's syndrome, thrombophlebitis, varicocele, varicose veins, vasculitis, ventricular hypertrophy without ischemic heart disease)	○	
105	Other hematological conditions (examples: elevated white blood cell count not associated with infection, elevated red blood cell count, polycythemia vera)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section D. Digestive Conditions

When you eat, your body breaks food down to a form it can use to build and nourish cells and provide energy. This process is called digestion. Your digestive system is a series of hollow organs joined in a long, twisting tube. It runs from your mouth to your anus and includes your esophagus, stomach, and small and large intestines. Your liver, gallbladder and pancreas are also involved. They produce juices to help digestion. There are many types of digestive disorders and conditions. The symptoms vary widely depending on the problem.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section D. Digestive Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
106	Bowel obstruction/blockage (example: colonic volvulus)	○	
107	Diverticulitis (inflammation/infection of the colon)	○	
108	Esophagus – inflammation (examples: acid reflux disease, Barrett's esophagus, gastroesophageal reflux disease, GERD)	○	
109	Gall stones (cholelithiasis)	○	
110	Gastritis (inflammation/infection of the stomach) and/or duodenitis (small intestine)	○	
111	Hemorrhoids – **with** surgery completed or recommended in the future	○	
112	Hernia, hiatal	○	
113	Hernia, inguinal, ventral, or umbilical	○	
114	Hernia, other – **without** surgery completed or recommended (example: incisional hernia)	○	
115	Intestines and abdomen – congenital anomalies (examples: congenital obstructions and occlusions, Hirschsprung's disease, Meckel's diverticulum, prune belly syndrome)		○
116	Intestines and abdomen – inflammation (examples: mesenteric adenitis, peritoneal abscess)		○
117	Intestines and abdomen – trauma (examples: foreign body in intestine and colon, physical trauma)	○	
118	Intestines and abdomen – vascular diseases (examples: intestinal ischemia, mesenteric infarction, reduced blood supply to the intestines)	○	
119	Irritable Bowel syndrome (IBS)	○	
120	Pancreatitis (inflammation/infection of the pancreas) – acute	○	
121	Pancreatitis (inflammation/infection of the pancreas) – chronic or ongoing		○
122	Rectum or anus infection – **with** surgery completed or recommended in the future (examples: abscess or ulcer)	○	
123	Rectum or anus infection – **without** surgery completed or recommended	○	

TABLE CONTINUED ON NEXT PAGE

Section D. Digestive Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
124	Rectum or anus inflammation – **with** surgery completed or recommended in the future (examples: anal fistula, rectal prolapse)		○
125	Stomach or esophagus – anomaly (examples: congenital hernia, gastroparesis)	○	
126	Stomach ulcer (example: peptic ulcer)	○	
127	Other gastroenterological conditions (examples: abdominal pain, diarrheal infection if treated by a physician, hemorrhoids **without** surgery completed or recommended, other hernia **with** surgery completed or recommended, rectum or anus inflammation **without** surgery completed or recommended)	○	
128	Other hepatic and biliary conditions (examples: fatty liver disease, jaundice not of newborn, Non-Alcoholic Steatohepatitis (NASH), splenomegaly - enlarged spleen, toxic or non-infectious hepatitis)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section E. Endocrine, Lymphatic or Metabolic Conditions

The foundations of the endocrine system are the hormones and glands. As the body's chemical messengers, hormones transfer information and instructions from one set of cells to another. Too much or too little of any hormone can be harmful to your body. The lymphatic system clears away infection and keeps your body fluids in balance. Lymph vessels, which are different from blood vessels, carry fluid called lymph throughout your body. If your lymphatic system is not working properly, fluid builds in your tissues and causes swelling. Other lymphatic system problems can include infections, blockage, and cancer. Metabolism is the process your body uses to get or make energy from the food you eat. Chemicals in your digestive system break the food parts down into sugars and acids, your body's fuel. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section E. Endocrine, Lymphatic or Metabolic Conditions:		*Fill in the circle for each condition you have (or had)*	
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*In the* ***last 12 months****?*	*In the* ***last 5 years****?*
129	Adrenal gland hyper-functioning (examples: adrenogenital disorders, Bartter's syndrome, Cushing's syndrome)		○
130	Diabetes Type II – **with** other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac, hypertension) (mark other conditions separately)		○
131	Diabetes Type II – **without** other health conditions		○
132	Diabetes Type I – **with** other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac, hypertension) (mark other conditions separately)		○
133	Diabetes Type I – **without** other health conditions		○
134	Nutritional deficiency (examples: malnutrition, Rickets, vitamin deficiencies)	○	
135	Thyroid gland conditions (examples: hypo- or hyper-functioning thyroid, congenital hypothyroidism)		○
136	Other diseases of endocrine glands (examples: carcinoid syndrome, congenital anomalies of other endocrine glands, precocious sexual development and puberty, Waldenström's macroglobulinemia)	○	
137	Other endocrinological conditions (examples: goiter, gout, hyper- or hypo-functioning parathyroid, hypogonadism)	○	
138	Other metabolic disorders (examples: cystinosis, disorders of iron metabolism, metabolic syndrome X, hypercalcemia, hyperkalemia, hyperpotassemia, hyponatremia, hypopotassemia, hyposmolality, monoclonal gammopathy, phenylketonuria (PKU), porphyria, xanthogranuloma)		○

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section F. Muscle, Skeletal or Skin Conditions

Musculoskeletal conditions comprise over one hundred diseases and syndromes, which are usually progressive, associated with pain, and involve your muscles, joints and bones. The largest organ in the body, the skin, is the first line of defense against dirt, germs and other foreign objects. Most skin disorders display symptoms on the surface of the skin.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section F. Muscle, Skeletal or Skin Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
139	Arthritis – adult rheumatoid		○
140	Arthritis – juvenile rheumatoid (under 17 years of age)		○
141	Autoimmune rheumatologic diseases except lupus and psoriasis (examples: ankylosing spondylitis, polymyositis, scleroderma, sicca syndrome, Sjörgen's syndrome)		○
142	Lupus		○
143	Psoriasis **with** arthritis		○
144	Bone and joint infection (example: osteomyelitis)	○	
145	Bursitis and tendonitis (not resulting in a loss of mobility)	○	
146	Joint and other soft tissue (tendons, muscles, cartilage, ligaments) – inflammation major (examples: costochondritis, fibromyalgia, inflammatory arthritis, lateral epicondylitis, myositis, osteochondritis dissecans, reflex neuromuscular dystrophy, tennis elbow)		○
147	Joint degeneration **with** surgery completed or recommended in the future (examples: ankylosis, degeneration of lumbar disc, degenerative arthritis, herniated disc, Osgood-Schlatter disease, osteoarthritis, osteochondropathy, pars defect, Perthes disease, sciatica, spinal stenosis, spondylosis)		○
148	Joint degeneration **without** surgery completed or recommended		○
149	Joint derangement (examples: chondromalacia, knee cartilage tears, dislocated joints, non-traumatic tendon ruptures, palindromic arthritis, torn meniscus)	○	
150	Orthopedic deformity (examples: Beal's syndrome, bunions, club foot, Crouzon's syndrome, Ehlers-Danlos syndrome, flat foot, ganglion, hammer toe, hip dysplasia, Marfan's syndrome, metatarsus varus, polydactyly, scoliosis, syndactyly, hip abscess)		○
151	Osteoporosis		○
152	Skin ulcers – chronic		○
153	Other orthopedic conditions (examples: lumbago, Profichet's disease, trigger finger, turf toe)	○	

TABLE CONTINUED ON NEXT PAGE

Section F. Muscle, Skeletal or Skin Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
154	Other skin conditions if treated by a physician (examples: acne, allergic skin reactions, boils, cellulitis, contact dermatitis, dermatomyositis, eczema, fasciitis pemphigus, fungal infections, morphea, pilonidal cyst, psoriasis **without** arthritis, rashes, rosacea, sebaceous cyst, skin abscesses, viral warts, vitiligo) – **NOT** MRSA or necrotizing fasciitis	○	
155	Other trauma (examples: ACL tears, amputations except bilateral leg, broken bones, burns including chemical burns covering less than 50% of the body, open wounds if treated by a physician, ruptured spleen, sprains, traumatic tendon ruptures, whiplash)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section G. Non-Psychiatric Conditions of the Nervous System

The nervous system is a complex, sophisticated system that regulates and coordinates body activities. Disorders of the nervous system may include the following: vascular disorders (such as stroke), infections (such as meningitis), structural disorders (such as brain or spinal cord injury), functional disorders (such as headache, epilepsy) and degeneration (such as Parkinson's disease, multiple sclerosis and Alzheimer's disease) are all examples of these disorders or conditions.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section G. Non-Psychiatric Conditions of the Nervous System:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
156	Brain trauma (examples: concussion, subdural hemorrhage **without** complications)	○	
157	Central nervous system – congenital disorders (examples: encephalopathy, essential tremor, Joubert syndrome, microcephaly) **NOT** Alzheimer's disease, ALS, or Parkinson's disease		○
158	Central nervous system – hereditary and degenerative diseases (examples: extrapyramidal disease and abnormal movement disorder, monomelic amyotrophy, myoclonus, obstructive hydrocephalus, spinal amyotrophy, syringomyelia, visceral myopathy)		○
159	Central nervous system – inflammation (examples: demyelinating disease of central nervous system, idiopathic peripheral autonomic neuropathy, paralytic strabismus, pseudotumor cerebri, vertigo of central origin)		○
160	Cerebral vascular accident (examples: brain bleed, cerebral atherosclerosis, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL), moyamoya disease, **stroke**, transient cerebral ischemia, transient ischemic attack (**TIA**), transient global amnesia)		○
161	Epilepsy		○
162	Meningitis (inflammation/infection of the lining of the brain and spinal cord)	○	
163	Migraine headache	○	
164	Nerves – carpal tunnel syndrome	○	
165	Nerves – traumatic disorders	○	
166	Nerves, cranial inflammation (affecting the head, face, eyes, tongue and/or throat including speech) (examples: atypical face pain, Bell's palsy, trigeminal neuralgia)	○	
167	Nerves, non-cranial inflammation – except carpal tunnel (examples: brachial plexus lesion, causalgia, Guillain Barre syndrome, meralgia paresthetica, myasthenia gravis, nerve lesions, neuralgia, neuralgic amyotrophy, neuritis, radiculitis, root lesions)	○	
168	Nerves, peripheral – congenital disorders (examples: idiopathic peripheral neuropathy, idiopathic progressive polyneuropathy)		○
169	Parkinson's disease		○

TABLE CONTINUED ON NEXT PAGE

Section G. Non-Psychiatric Conditions of the Nervous System:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
170	Spinal trauma **without** paralysis or surgery completed or recommended (example: dislocated vertebrae)	○	
171	Other neurological conditions (examples: Alzheimer's disease, convulsions, dementia, isolated seizure, myelitis)		○
172	Other neurological diseases (examples: encephalitis, idiopathic hypersomnia, insomnia, narcolepsy, reaction to spinal or lumbar puncture, restless leg syndrome, verbal apraxia)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section H. Psychiatric (Mental Health) Conditions

Mental illness is any disease or condition affecting the brain that influences the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section H. Psychiatric (Mental Health) Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
173	Mood disorder - bipolar (example: cyclothymic disorder)		○
174	Mood disorder - depression (example: dysthymia)		○
175	Opioid or barbiturate dependence (examples: heroin, codeine, morphine, oxycodone dependence)		○
176	Psychotic and schizophrenic disorders (examples: hebephrenia, paranoia)		○
177	Other mental health conditions (examples: adjustment disorders, anxiety disorders, Asperger's syndrome, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), eating disorders, erectile dysfunction if mental, mild autism, panic disorders, phobias, post traumatic stress disorder, seasonal affective disorder)		○
178	Other substance abuse conditions (examples: acute alcohol intoxication requiring medical attention, alcoholism, amphetamine dependence, cannabis dependence, cocaine dependence)		○

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section I. Respiratory Conditions

The respiratory system consists of the airways, the lungs, and the respiratory muscles that control the movement of air in and out of the body. Within the lungs, molecules of oxygen and carbon dioxide are exchanged between the air we breathe and the blood. Respiratory disease includes problems that obstruct or restrict breathing and include breathing problems from infection, the environment, or other diseases.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section I. Respiratory Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
179	Acute respiratory distress syndrome	○	
180	Asthma (example: reactive airway disease)		○
181	Chronic obstructive pulmonary disease (examples: emphysema, obstructive chronic bronchitis)		○
182	Occupational and environmental pulmonary diseases (examples: asbestosis, black lung disease, bronchitis due to fumes and vapors, silicosis)		○
183	Pneumonia – fungal (example: aspergillosis)	○	
184	Other inflammatory lung diseases (examples: post inflammatory pulmonary fibrosis, sarcoidosis)		○
185	Other pulmonary conditions (examples: acute bronchitis, bacterial or viral pneumonia, congenital pulmonary conditions, flu if treated by a physician)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section J. Urinary, Genital, and Reproductive Conditions

Urinary conditions are comprised of problems with how the kidneys, ureters, bladder, and urethra function. The female reproductive system is made up of the vagina, womb (uterus), fallopian tubes and ovaries. The male reproductive system is made up of the penis, the testicles, the epididymis, the vas deferens and the prostate gland.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section J. Urinary, Genital, and Reproductive Conditions:		*Fill in the circle for each condition you have (or had)*	
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*In the* ***last 12 months****?*	*In the* ***last 5 years****?*
186	Endometriosis		○
187	Female genital system diseases (example: dyspareunia)	○	
188	Female sex gland disorders (examples: ovarian failure, polycystic ovaries)		○
189	Genitourinary system – inflammation including torsion of the testes (examples: hydrocele, spermatocele)	○	
190	Interstitial cystitis – chronic (examples: Hunner's ulcer, persistent inflammation of the bladder)	○	
191	Kidney infection	○	
192	Kidney or bladder stones	○	
193	Renal conditions (example: polycystic kidney)	○	
194	Renal failure – acute	○	
195	Renal failure – chronic		○
196	Renal inflammation – acute (example: IgA nephropathy)	○	
197	Renal inflammation – chronic (example: glomerulonephritis)		○
198	Other gynecologic conditions (examples: Bartholin's gland conditions, dysmenorrhea, hematometra, menopausal conditions, metrorrhagia, problems with menstruation, vaginal infection including yeast infections, vaginitis)	○	
199	Other nephritic conditions (examples: excess protein in urine, lesions in the kidneys)	○	
200	Other urologic conditions (examples: bladder infection, blood in the urine, epididymitis, erectile dysfunction if physical, hematoma of the kidney, gonorrhea, orchitis, prostatitis, sexually transmitted diseases infecting the genitals, trauma to the genitourinary system, urinary tract infection)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section K. Other Conditions

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section K. Other Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
201	Adverse environmental exposures (examples: angioedema, food allergies, heat stroke, electrocution – mark any burns from the electrocution separately)	○	
202	Chromosomal anomalies (examples: autosomal deletions, Cri du Chat syndrome, Down's syndrome, Edwards' syndrome, Klinefelter's syndrome, Patau's syndrome, Prader-Willi syndrome, Turner's syndrome, Velo Cardio Facial syndrome (VCFS)) **NOT** Fragile X syndrome		○
203	Eye – cataract		○
204	Eye – internal infection (examples: chorioretinitis, endophthalmitis, pars planitis, viral infections of the inner eye, vitreous abscess)	○	
205	Eye – glaucoma or other intra-occular hypertension		○
206	Eye – macular degeneration		○
207	Eye – retinopathy (example: diabetic retinopathy)		○
208	Immunodeficiencies – deficiency of humoral immunity (examples: common variable immunodeficiency, hypogammaglobulinemia)		○
209	Immunodeficiencies – other (example: Wiskott-Aldrich syndrome)		○
210	Mental retardation		○
211	Poisonings and toxic effects of drugs (examples: all drug reactions, venomous bites)	○	
212	Septicemia **with** septic shock	○	
213	Sexually transmitted diseases disseminated to other parts of the body (examples: chlamydia outside the genitals, Reiter's disease)	○	
214	Sinusitis – chronic (examples: more than 3 sinus infections in past 12 months, allergic sinus reactions, hay fever, chronic rhinitis)		○
215	Tuberculosis – pulmonary	○	
216	Tuberculosis – disseminated (tuberculosis spread to other organs beyond the lungs)		○
217	Other ear, nose, and throat conditions (examples: acute sinusitis, cochlear implants, ear infections, hearing disorders, hearing loss, nasal congestion if treated by a physician, sleep apnea, sore throat if treated by a physician, tinnitus, tonsillitis)	○	

TABLE CONTINUED ON NEXT PAGE

Section K. Other Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
218	Other eye conditions except minor vision problems (nearsightedness, farsightedness) (examples: blepharitis, chalazion, conjunctivitis, drooping eyelids, eye wandering, injury to the cornea, lazy eye, macular edema, meibomitis, optic neuritis, pink eye, retinal tear, strabismus, stye)	○	
219	Other infectious diseases (examples: anthrax, chicken pox, cold sores, dengue fever, E. Coli infection, gangrene, herpes simplex, infectious mononucleosis, lyme disease, malaria, MRSA infecting the skin or lungs, parasitic infection, pertussis, rabies, septicemia **without** septic shock, shingles, small pox, staph infection, tetanus, viral infections, West Nile virus, Whipple's disease, whooping cough)	○	
220	Other neonatal conditions (examples: jaundice in newborns, croup)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section L. Write-in Conditions

Have you been diagnosed, treated, medicated, and/or monitored for other medical conditions in the last 5 years not listed in any previous Sections? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, in the table provided below indicate which conditions and fill in the circle(s) for each applicable time frame that applies to you.*

○ No *If NO, continue on to Part 3.*

Section L. Write-In Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *List the name of the condition, not the procedure or drug used to treat the condition. For example list the cause of knee replacement not the knee replacement itself.*	*Fill in the circle for each condition you have (or had)*	
	In the ***last 12 months****?*	*In the* ***last 5 years****?*
	○	○
	○	○
	○	○
	○	○
	○	○
	○	○
	○	○

The scoring for certain write-in conditions can be viewed on WSHIP's website, under the link "Guide to Marking Medical Conditions on the Standard Health Questionnaire": www.wship.org

Note that certain rare conditions, even if not specifically listed in this document, may result in a score above the denial threshold. For these conditions to be scored above the threshold 1) it must be verified that the condition is rare by viewing the National Institute of Health's list of rare conditions at http://rarediseases.info.nih.gov/RareDiseaseList.aspx; and 2) the average annual health care cost of treating the condition must be shown to have an average annual cost above the threshold (8% most costly) set by statute. If further information is needed, please contact a carrier or agent.

The following conditions and information are not scored and do not need to be included:

- Any condition for which you have not sought licensed medical advice
- Coughs
- Dental conditions treated by a dentist
- Fevers
- General malaise or fatigue
- Information about your family history or any experience with genetic testing, genetic counseling, or other genetic services that are not related to diseases you have currently
- Minor joint pain treated with over the counter (OTC) medications and that have not been diagnosed by a specialist; this may be called arthritis but no determination of which kind of arthritis has been made
- Nearsightedness or farsightedness
- Pregnancy or pregnancy related conditions (gestational diabetes, varicose veins in pregnancy)
- Preventive or routine screenings without abnormal results

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

PART 3. SIGNATURE AND SCORING PAGE

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following:**

1. **All of the information I have given is true and complete**.
2. I understand that if I leave an answer blank to an individual condition it is the same as a "No" answer.
3. If I answered "No" to Section A, I have completed all remaining Sections, B through L of Part 2, and indicated "Yes" or "No" at the top of each Section, B through L.
4. I understand that if I omit or give false information I may lose my coverage, in which case I may have to pay for services paid under that coverage.
5. **I understand that if I intentionally give false information, in addition to losing my coverage, I may incur additional legal liability.**

If you do not sign and date this questionnaire below, it will be returned to you and your application will be delayed. Your signed questionnaire will be valid for a 90-day period from the date you sign it. If you wait more than 90 days to submit your application, you will have to complete a new questionnaire. To be complete, the page 2 exemptions list and Parts 2 and 3 of your questionnaire must have been filled out.

Please print name, then sign and date in the space provided.

First Name ______ M.I. ___ Last Name ______

______ / ______ / ______

Signature **Date Signed**

If you are signing on behalf of an underage child, check: ☐ **Parent** ☐ **Legal Guardian**

THANK YOU FOR COMPLETING THE STANDARD HEALTH QUESTIONNAIRE

This questionnaire is updated periodically. In an effort to continually improve the questionnaire, we have included a brief survey on our website. If you would like to provide feedback on your experience filling out this questionnaire, please go to the following web address: **www.wship.org/SHQsurvey**. This brief survey is optional and has no effect on your score.

FOR HEALTH CARRIER USE ONLY. DO NOT MARK THIS SECTION.

Name of health carrier

Date Reviewed ___ / ___ / ___ Reviewer ID ______ Member SSN (optional) ______

	Condition #	Score		Condition #	Score		Condition #	Score
1.			5.			9.		
2.			6.			10.		
3.			7.			11.		
4.			8.			12.		

Total Score ______ ○ Applicant Accepted ○ Applicant Denied