Employee Name		Social Security Number		Date of Birth
Mailing address		City/County	State GA	Zip Code
Gender ☐ Male ☐ Female	Date employed full-time	Job Title	Phone Number	
Marital Status ☐ Single ☐ Married Marriage Date: _____	Email		Employer Name	
Employee's Height ____ ft. ____ in. Weight _____ lbs				
If waiving coverage for you OR any of your dependents, please indicate reason: ☐ No Coverage ☐ Other Coverage ☐ Covered under spouse. Need Employer Name: _____				

NOTE : This form is used for quoting purposes ONLY. Please notify HR for any changes to your coverage

(Please circle one):

Medical:	Emp only	Emp & SP	Em & Child(ren)	Family	Decline
Dental:	Emp only	Emp & SP	Em & Child(ren)	Family	Decline
Vision:	Emp only	Emp & SP	Em & Child(ren)	Family	Decline

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children)

Spouse:	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Height ____ ft. ____ in. Weight: _____	Court Ordered Healthcare? ☐ Yes ☐ No		Live with you? ☐ Yes ☐ No
Child #1	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Height ____ ft. ____ in. Weight: _____	Court Ordered Healthcare? ☐ Yes ☐ No		Live with you? ☐ Yes ☐ No
Child #2	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Height ____ ft. ____ in. Weight: _____	Court Ordered Healthcare? ☐ Yes ☐ No		Live with you? ☐ Yes ☐ No
Child #3	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Height ____ ft. ____ in. Weight: _____	Court Ordered Healthcare? ☐ Yes ☐ No		Live with you? ☐ Yes ☐ No
Child #4	Social Security Number	Date of Birth	Gender ☐ Male ☐ Female
Height ____ ft. ____ in. Weight: _____	Court Ordered Healthcare? ☐ Yes ☐ No		Live with you? ☐ Yes ☐ No

Coverage:

Do you have any current or past benefits insurance coverage prior to taking new coverage through this employer? ☐ No Coverage ☐ Coverage: _____ ☐ Employer Name: _____
Are you or any family members who may be covered by your benefits currently covered by Medicare? ☐ No Coverage ☐ Coverage ☐ Person enrolled: _____

Health:

Within the past **5 years,** please answer the following questions with respect to you, or any of your covered dependents:

If you check yes to any of the question below you **MUST provide DETAILS** on last page or on a separate sheet.

Currently taking any prescription for any medical condition?	☐ Yes	☐ No
Had surgery or anticipate having surgery in the future, aside from pregnancy?	☐ Yes	☐ No
Have a past or current health condition, illness, or injury that required surgery or that may require surgery in the future?	☐ Yes	☐ No

Employee Name: _____

Have you or any family members who may be covered by your benefits been treated for any of the following diseases, illnesses, injuries, disorders or health issues?		
Allergies / Skin Acoustic Neuroma, Allergies, Blindness, Cataracts, Chronic Ear Infections, Deafness, Ear Disorder, Ear Drainage Tubes, Eye Disorder, Glaucoma, Hay Fever, Nose Disorder, Other Disease of skin, Otitis Media (Ear Infection), Psoriasis, Skin disease or disorder, Skin Ulcer, Speech/Hearing Impairments, Throat Disorder.	☐ Yes	☐ No
Autoimmune AIDS / ARC / HIV	☐ Yes	☐ No
Blood / Circulatory Anemia, Aneurysm, Bleeding problems or disorders, Blood Clot, Erythrocytosis / Polycythemia / Hemoglobin Kempsey, Hemophilia, Hemorrhoids, *High Blood Pressure, Hypertension, *High cholesterol, High triglycerides, Hypoglycemia, Low Blood Pressure, Other blood disease or disorder, Other Neurological Disorders, Peripheral Vascular Disease, Phlebitis, Raynaud's Syndrome, Sickle Cell Anemia, Thrombophlebitis, TIA. Varicosities. Vascular Disease. *High Blood Pressure MUST HAVE Recent reading & date _____ _____ *High Cholestrol MUST HAVE Recent reading & date _____ _____	☐ Yes	☐ No
Brain / Head Autism, Concussion, Head injury, Epilepsy, Memory Loss, Migraines.	☐ Yes	☐ No
Cancer Breast Cancer, Cancer of the Skin, Chemotherapy, Colon Cancer, Cysts, Growths, Hodgkin's Disease, Leukemia, Liver Cancer, Lung Cancer, Lymphoma, Malignancy, Melanoma, Other Cancer, Prostate Cancer, Radiation Therapy, Testicular Cancer, Tumor or dysfunction of breast, Tumor or dysfunction of reproductive organs, Tumors / Growths.	☐ Yes	☐ No
Endocrine / Lymphatic Addison's Disease, *Diabetes Mellitus (Type II), Disease of Lymph Nodes, Gestational Diabetes, Goiter, Growth Hormones, Hyperthyroidism, Hypothyroidism, Lymphadenopathy, Other Glandular Disease/Disorder, Pituitary Dwarfism, Retinopathy, Spleen, Sugar in Urine, Swollen Glands, Thyroid disease or disorder, Tonsillitis, *Type 1 Diabetes (Juvenile Diabetes). *Diabetes ☐ Type 1 ☐ Type 2 Recent A1C reading & date _____ Last 3 sugar level readings _____ _____ _____	☐ Yes	☐ No
Gastrointestinal Bowel or intestinal disorder, Cirrhosis of Liver, Colon Disorder, Colon Polyps, Crohn's Disease / Ulcerative Colitis, Diverticulitis, Gall Stones, Gallbladder Disease or problems, Gastric / Peptic Ulcer, Gastric Bypass, Gastric Reflux, Hepatitis, Hernia, Ileostomy, Intestinal Polyps, Intestine Disease or Disorder, Jaundice, Other Bowel / Stomach Disorders, Other Liver problems/disorders, Pancreatitis or Pancreas Disease, Rectal Bleeding, Rectal Disorders, Stomach Disorder, Stomach Ulcer, Ulcerative Colitis.	☐ Yes	☐ No
Genitourinary Abnormal Pap, Albumin or blood in urine, Bladder, Cystitis, Dialysis, End Stage Renal Disease (ESRD), Kidney Excision, Kidney Failure (Renal Failure), Kidney Stones, Neurogenic Bladder, Other Kidney Problems (CRI / CKD) or Disorders, Polycystic Kidney Disease, Proteinuria, Testicular, Urinary Problems or Disorders, Uterine.	☐ Yes	☐ No
Heart Angioplasty, Bypass Surgery, Cardiomyopathy, Carotid Artery Disease, Chest pain, Circulatory Problems / Disorders, Congestive Heart Failure, Coronary Artery Disease, Coronary Insufficiency, Defibrillator, Heart Attack / M.I., Heart Disease, Heart murmur, Heart Surgery, Heart/Circulatory, Irregular Heartbeat, Ischemic Heart Disease, Open Heart Surgery Candidate, Other Heart Disorders, Pacemaker, Pericarditis, Regurgitation / prolapse (mitral valve), Stroke, Vasculitis, Veins / circulatory system.	☐ Yes	☐ No
Immune ANA-antinuclear antibodies, Autoimmune disorder, Graves' Disease, Guillain Barre Syndrome, Immune Deficiency Disorder, Lupus, Multiple Sclerosis, Other immune disorders, Rheumatoid Arthritis.	☐ Yes	☐ No
Mental / Emotional Adjustment Reactions, Alzheimer's Disease, Anorexia / Bulimia, Anxiety, Attempted Suicide, Attention Deficit Disorder, Bipolar/Manic Depression, Chronic Depression, Depression, Eating disorder, Mental disorder, Nervous (Neurological) system disorder, Other Mental / Emotional Disorders, Professional counseling, Psychotic Disorder, Schizophrenic Disorders, Stress.	☐ Yes	☐ No

Employee Name: _____

Musculoskeletal Amputations or Prosthetics, Amyotrophic Lateral Sclerosis (ALS- Lou Gehrig's Disease), Back / Spinal Disorder, Back/Sprain, Bulging/Herniated Disc, Bursitis, Carpal tunnel syndrome, Cerebral Palsy, Connective Tissue Disease, Degenerative disc disorder, Degenerative Joint Disease, Extremity / Limb injuries (fractures) or disorders, Fibromyalgia (FM), Gout, Head or Spinal, Joint pain or Disorder (inc. Polymyalgia Rheumatica), Joint replacement, Manipulation Therapy, Muscle pain or disorder, Muscle/Joint/Bone pain, disease or disorder, Muscular Dystrophy, Muscular Sclerosis, Myasthenia Gravis, Neck Pain, Osteoarthritis, Paralysis, Paraplegia, Quadriplegia, Scleroderma, Scoliosis, Spina Bifida, Spinal Disc Disease, Strained or Pulled Muscle, Tendonitis, TMJ, Torn Ligament.	☐ Yes	☐ No
Pregnancy / Reproductive Disorders Abnormal menstrual period, Adoption Planned, Birth Control, Breast Augmentation or Reduction, Breast disease or disorder, Breast Lump, Cesarean Section, Complications related to pregnancy, Currently Pregnant, Endometriosis, Enlarged Prostate, Expectant Parent, Fibrocystic Breast Disease, Fibroids, Genital Warts, Herpes Simplex, High Risk Pregnancy, Hysterectomy, Infertility, Infertility (Female), Infertility (Male), Miscarriage, Multiples Expected, Other Reproductive disease/disorder, Ovarian Cysts, Pelvic Inflammatory Disease, Primary Syphilis, Prostate Disease, Disorder or Problem, Secondary Syphilis, Sexually Transmitted Disease (Not Listed), Tertiary Syphilis, Testicular Disorder or Disease, Transurethral resection, Venereal	☐ Yes	☐ No
Respiratory / Lung Asthma, Ataxia, Atelectasis, Chronic Bronchitis, Chronic Obstructive Pulmonary Disease (COPD), Chronic Sinusitis, Cystic Fibrosis, Deviated Nasal Septum, Disease of the Throat, Dizziness, Emphysema, Fainting, Headaches, Hydrocephalus, Meningitis, Motor/Sensory Aphasia, Other Lung Disorders, Pneumonia, Seizure, Shortness of breath, Sleep Apnea, Sleep disorder, Tuberculosis.	☐ Yes	☐ No
Substance Abuse Addiction, Alcohol Dependency, Drug Dependency.	☐ Yes	☐ No
Transplant / Organ Removal Appendicitis / Appendectomy, Discussed Possible Future Transplant, Organ Removal, Possible Future Transplant, Transplant, Transplant (Bone Marrow).	☐ Yes	☐ No
Other Conditions Abdominal or Pelvic Pain, Accident, Brain disease or disorder, Chronic Fatigue, Cleft lip/palate, Congenital Disease / Defect, Convulsions, COVID-19, Deformities, Disabilities, or Handicap, Fever, Loss of Consciousness, Lyme's Disease, Malaise, Night Sweats, Obesity, Other Condition, Parkinson's Disease, Rash, Receiving treatment, Rheumatic fever, Tremors, Unexplained Weight Change. Receive SSDI? ☐ Yes ☐ No	☐ Yes	☐ No
Tobacco/Nicotine use in the past 5 years? — **MUST COMPLETE ALL BOXES BELOW** ☐ Employee ☐ Spouse ☐ Child Product type: ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Chewing tobacco ☐ e-cigarettes Date Started: _____ Date Ended: _____ ☐ Light Use ☐ Heavy Use AVG QTY: _____ Have you used tobacco or nicotine more than 4 times per week on average (excluding religious or ceremonial uses)? ☐ Yes ☐ No Are you participating in a Smoking Cessation Program? ☐ Yes ☐ No Are you willing to complete a Smoking Cessation Program? ☐ Yes ☐ No	☐ Yes	☐ No
Are you or any family members who may be covered by your benefits or any dependent currently pregnant or adopting? (Including any dependent not applying for coverage?	☐ Self ☐ Dependant Name:_____	☐ Yes ☐ No
Have you or any family members who may be covered by your benefits used, been treated, or counseled (e.g. Addicts Anonymous, Alcoholics Anonymous, "Step" Program or any individual or group therapy) due to use of alcohol, sedatives, hallucinogens, illegal substances, narcotics or any other drugs other than those prescribed by a physician in the last 5 years?	☐ Self ☐ Dependant Name:_____	☐ Yes ☐ No

Employee Name: _____

Visited any health care professional, or thought you should seek treatment, for any illness, injury, or health condition?	☐ **Yes**	☐ **No**
Have you or any family members who may be covered by your benefits had a physical exam in the last 5 years?	☐ **Yes**	☐ **No**
Have you or any family members who may be covered by your benefits been declined for life or health insurance coverage from any carrier?	☐ **Yes**	☐ **No**
Visited a healthcare professional for any illness and/or medical condition resulting in medical expenses more than $5,000 in the past 5 years?	☐ **Yes**	☐ **No**
Have a condition or treatment that involves Worker's Compensation? List condition below.	☐ **Yes**	☐ **No**

If you check yes to any of the question below you **MUST provide DETAILS** on below or on a separate sheet.

Person Treated	**Treatment Dates** From To	**Diagnosis/Cause of illness or condition**	**Treatment/Medications Dosage & Frequency**	**Any current symptoms/ Last Readings & Dates**
Example- Jane Doe	***MM/YR - MM/YR***	***High Blood Pressure***	***Lisinopril 10mg one a day***	***120/80 10/2022 under control***

Person Treated	**Hospital/ Surgery Dates** From To	**MUST** provide **DETAILS** of hospitalization and/or surgery **(past or future)** (ex. Condition, treatment, testing, any complications, degree of recovery, …etc)
Example- Jane Doe	***MM/YR - MM/YR***	***Left knee joint pain treated with shots first, then had knee replacement surgery, no complications, completed physical therapy, completely recovered***

Disclosure Authorization: All Data will be Confidential. We are required by law to keep such data confidential. It will be seen by Partners Benefit Group and authorized insurance companies. I declare that all statements and information made hereon are complete and true to the best of my knowledge. I understand that any intentional misstatements or omissions may void coverage applied for on this questionnaire.

Employee Signature: _____ **Date:**_____