INFORMATIONAL FORM

MEMBER IN	IFORMATION							
	Coverage Type: EE / E+Sp / E + Child / Family							
Last Name:	First Name:							
Member SS#:	Date of Birth:							
Home Phone:	Email:							
Mobile Phone:	Effective Date:							
Gender: Male Female	Height: Weight:							
Street Address:	Apt#:							
City:	State:							
Zip Code:	Marital Status: Single Married Divorced							
EMPLOYMENT INFORMATION								
Business Name:	Business Phone:							
Occupation/Industry:	Business Email:							
Business Address:	Employment Start Date: Compensation Type: Hourly Salary							
Actively Employed: Yes No	Hours Worked Per Week:							
SPOUSE INFORMA	ATION (If Applicable)							
Last Name:	First Name:							
SS# Height: Weight:	Date of Birth							
DEPENDENT INFORM	MATION (If Applicable up to age 26)							
Last Name:	First Name:							
SS# Height: Weight:	Date of Birth: GENDER M F							
Last Name:	First Name:							
SS# Height: Weight:	Date of Birth: GENDER M F							
Last Name:	First Name:							
SS# Height: Weight:	Date of Birth: GENDER M F							
Last Name:	First Name:							
SS# Height: Weight:	Date of Birth: GENDER M F							
Mother's Ma	aiden Name:							

	In the past 5 years has medications, tests,		-		_				-		
	ttack, brain tumor, stroke, he	art dised	ase or		e. Kidney failure colon or blad		or diso	rder of the l	iver, stom	ach, pancre	as,
		YES		NO					YES	NO	
b. <i>Cancer,</i>	tumor, lymphoma, or any ty	pe of tra	nsplant?		f. Seizures, epile	epsy, hem	ophilia,	Sleep Apne	or blood	disorder?	
		YES		NO					YES	NO	
c. Any sur	gery or hospitalization in the	last 5 ye	ars, OR an	y currently	g. Diabetes, en	docrine, A	uto Imn	nune, Crohn	's Disease	or Arthritis	
· ·	planned or recommended?	YES		NO	or pituitary di disorder, lupu			V+?	YES	NO	
d. <i>Emphys</i>	sema or COPD?				h. Currently pre		emature	delivery, o	r multiple	births?	
		YES		NO	Pending due	date			YES	NO	
l. Are y	ou taking or have you taken	any med	ications in	the last 12 r	nonths? (If yes y	ou must li	ist all be	low.)	YES	NO	
Medication	n Name		Medication	Dosage			N	ledication Fro	equency		
	If you answered YES to	o ANY o	f the abov	ve Health Q	uestions, pleas	e provid	e expla	nations in	boxes be	elow	
Letter:	Applicant Name:	Conditio	on/ Diagnosi	s:	Date of onset:	Date of re	ecovery?	Current Tro	eatment?	Taking Med	ication? NO
_			T				l _			11.3	140
Treatment	Given or needed?		Medicatio	on names:			Surgery	or Hospitaliz	ation?		
		ı			T	I				ı	
Letter:	Applicant Name:	Conditio	n/ Diagnosi	s:	Date of onset:	Date of re	ecovery?	Current Tre	eatment?	Taking Med	ication?
								YES	NO	YES	NO
Treatment	Given or needed?		Medicatio	on names:			Surgery	or Hospitaliz	ation?		
		1	1		I	ı	l			ī	
Letter:	Applicant Name:	Conditio	n/ Diagnosi	s:	Date of onset:	Date of re	ecovery?	Current Tre	atment?	Taking Med	lication?
								YES	NO	YES	NO
Treatment	Given or needed?		Medicatio	on names:			Surgery	or Hospitaliz	ration?		

			_
Requested effective date (mn	n/dd/year)	/	
Billing Information – Invoices	should be sent to:		
Contact Person	1	itle	_
Company Name			_
Address			
City	State	Zip Code	
Telephone	F	ax	_
	Represe	ntative:	
Payment Options;			
	EFT AUTHORIZ	ZATION	
Bank Route Code#	Bank Ac	ecount#	_
Bank Route Code#	Bank Ac	ecount#	_
Bank Route Code#	Bank Ac	ecount#	_
Bank Route Code#	Bank Ac	ecount#	_
Bank Route Code#	Bank Ao	ecount#	_
Bank Route Code#	Bank Ao	ecount#	_
Bank Route Code#	Bank Ao	ecount#	
Bank Route Code#	Bank Ao	ecount#	