Employee Application Medical Questionnaire

Please Complete Entire Form in BLACK INK

Offered by
Quartz Health Plan Corporation

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QuartzBenefits.com

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions below. The date that this application is signed is the date from which you should use when answering questions that request you to provide prior history for various periods of time.

I. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):

1. CIRCULATORY SYSTEM
- a) heart disease or disorder ☐ Yes ☐ No
- b) stroke ☐ Yes ☐ No
- c) circulatory disorder ☐ Yes ☐ No
- d) chest pain ☐ Yes ☐ No
- e) high or low blood pressure ☐ Yes ☐ No
- f) elevated cholesterol and / or triglyceride levels ☐ Yes ☐ No
- g) anemia or blood disorder ☐ Yes ☐ No

2. DIGESTIVE SYSTEM
- a) ulcers ☐ Yes ☐ No
- b) stomach disorder ☐ Yes ☐ No
- c) liver / pancreas disorder ☐ Yes ☐ No
- d) gallbladder disorder ☐ Yes ☐ No
- e) intestinal disorder (e.g. colitis, Crohn's disease) ☐ Yes ☐ No
- f) hernia ☐ Yes ☐ No
- g) rectal disorder ☐ Yes ☐ No

3. GENITOURINARY SYSTEM
- a) menstrual disorder ☐ Yes ☐ No
- b) genital disorder ☐ Yes ☐ No
- c) sexual dysfunction ☐ Yes ☐ No
- d) pregnancy complications (e.g. premature birth, miscarriage, c-section) ☐ Yes ☐ No
- e) infertility ☐ Yes ☐ No
- f) urinary tract / kidney / bladder disorder ☐ Yes ☐ No
- g) prostate disorder ☐ Yes ☐ No

4. ENDOCRINE SYSTEM
- a) diabetes ☐ Yes ☐ No
- b) thyroid disorder ☐ Yes ☐ No
- c) adrenal disorder ☐ Yes ☐ No
- d) enlargement of the lymph nodes ☐ Yes ☐ No
- e) connective tissue disorder ☐ Yes ☐ No

5. RESPIRATORY SYSTEM
- a) allergies ☐ Yes ☐ No
- b) asthma ☐ Yes ☐ No
- c) emphysema ☐ Yes ☐ No
- d) sinus or nasal disorder ☐ Yes ☐ No
- e) lung disease or disorder ☐ Yes ☐ No
- f) shortness of breath ☐ Yes ☐ No

6. MUSCULAR or SKELETAL
- a) arthritis ☐ Yes ☐ No
- b) fibromyalgia ☐ Yes ☐ No
- c) back disorder ☐ Yes ☐ No
- d) joint disorder ☐ Yes ☐ No
- e) musculoskeletal disorder ☐ Yes ☐ No
- f) skin disorder ☐ Yes ☐ No
- g) chronic fatigue syndrome ☐ Yes ☐ No

7. NERVOUS SYSTEM
- a) epilepsy or other seizures ☐ Yes ☐ No
- b) headaches ☐ Yes ☐ No
- c) multiple sclerosis ☐ Yes ☐ No

8. CANCER
- a) cancer ☐ Yes ☐ No
- b) tumor ☐ Yes ☐ No
- c) abnormal growth ☐ Yes ☐ No
- d) carcinoma in situ ☐ Yes ☐ No

9. EAR OR EYE
- a) eye disorder ☐ Yes ☐ No
- b) ear disorder ☐ Yes ☐ No

10. BEHAVIORAL HEALTH
- a) attention deficit disorder ☐ Yes ☐ No
- b) psychological disorder ☐ Yes ☐ No
- c) suicide attempt ☐ Yes ☐ No
- d) eating disorder ☐ Yes ☐ No

11. OTHER
- a) organ or other type of transplant or implant ☐ Yes ☐ No
- b) breast disorder ☐ Yes ☐ No
- c) lupus ☐ Yes ☐ No

II. Within the last 5 years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any condition not already listed; been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? We are not seeking the results of HIV Antibody test.

☐ Yes

☐ No

III. In the space below please list and provide the complete details if you answered "Yes" above to any of the questions or conditions. **(Attach additional pages as needed and sign the additional pages.)**

Name of Person	Date(s) of Treatment	Give full details for each question answered "Yes," state the condition, duration and degree of recovery.	Name and address of attending physician or other health care provider.
First Last	___/___/___		Name Address Line 1 Address Line 2 City State ZIP Code
First Last	___/___/___		Name Address Line 1 Address Line 2 City State ZIP Code
First Last	___/___/___		Name Address Line 1 Address Line 2 City State ZIP Code

I certify that the information above is, to the best of my knowledge and ability, complete and true.

Applicant's Signature: _____ Date_____