



Individual Underwriting Questionnaire

Employer: _____

Policy Number: _____

Section I- Personal Information

Employee Name					
Last	First	Initial	Social Security Number	Date of Birth	Sex
Marital Status					
Employee Mailing Address:					
Employer's Name:					
Date of Hire:			Date Employed Full Time:		

The Employee Benefit Plan is Providing Medical Coverage For:

- Employee Only
 Employee & Children
 Employee & Spouse Only
 Family

Name of Dependent	Relationship to Employee	Date of Birth	Present Height (ft.) (in.)	Present Weight (pounds)	Regular Physician & Phone No.
	Self				
	Spouse				
	Child				
	Child				
	Child				

Section II- Life and Health Questions (This section must be filled out completely)

The employee must answer the following questions. Please answer them fully and truthfully. Please understand that this is not an application for health insurance for you, your spouse and/or your dependents. Your employer is applying for medical stop loss insurance to insure against excess losses incurred by its self-funded employee benefit plan (The Plan) as listed above. The only way your employer can obtain this medical stop loss insurance is you report all health information being asked for on this questionnaire. No one is authorized to change this requirement in any manner. If there are any omissions or misstatements on this questionnaire, the medical stop loss coverage may be rescinded or reimbursement claims under the policy may be denied.

- Is anyone named in this questionnaire:
 - Currently pregnant? (If yes, expected due date: _____) ... Yes No
 - Any previous high risk pregnancy?..... Yes No
 - Currently taking any medications prescribed by a physician? (If yes, please list all Medications below) Yes No
 - Now disabled or unable to perform normal work or age-related activities? (If yes, please identify names, conditions and dates of disability below) Yes No

2. Has anyone named in this questionnaire ever been diagnosed or tested positive as having an immune system disorder, including acquired immune deficiency syndrome, AIDS), or AIDS related complex (ARC) only if diagnosed, or HIV virus?..... Yes No
3. Within the last five years, has anyone named in this questionnaire been advised or scheduled to have surgery or an diagnostic test not yet completed..... Yes No
4. Within the last 10 years, has anyone named in this questionnaire been seen, counseled, consulted or treated for:

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Stroke, Circulatory Disorder, Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer, Tumor or Abnormal Growth
<input type="checkbox"/>	<input type="checkbox"/>	Connective Tissue Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema, Asthma, TB, Lung Disease or Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Seizures, Epilepsy, Paralysis, Convulsions
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Anemia or Blood Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Lupus	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Abuse, Mental/Nervous disorder	<input type="checkbox"/>	<input type="checkbox"/>	Kidney, Bladder, Prostate Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Back, Joint or Muscle Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Uncontrollable/Complication or Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Menstrual/Gynecological Disorder, Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Congenital Abnormalities
<input type="checkbox"/>	<input type="checkbox"/>	Organ/Tissue Transplant (past/pending)			

5. Within the last five years, has anyone named in this questionnaire had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above? Yes No

IN THE SPACES BELOW, PLEASE LIST MEDICATIONS AND PROVIDE FULL DETAILS TO QUESTIONS FOR WHICH YOU ANSWERED, "YES" ABOVE. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

Question No.	Name of Family Member	Dates of Treatment	Date of Full Recovery	Identify the Condition/Type of Treatment Received	Name/Phone # of Attending Physician

Disclosures, Authorization and Signature

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no individual or group health insurance coverage will be issued to me, my spouse and/ or my dependents by Perico Life Insurance Company as a result of my completion of this questionnaire. I further understand and agree that all medical coverage provided to me, my spouse and/ or my dependents is or will be subject to the terms and conditions of the Employee Benefit Plan as approved by Perico Life Insurance Company.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, government agency, insurance company or other organization or person that has any records or knowledge of me or any family member for whom coverage is provided under the aforementioned Employee Benefit Plan, to give Perico Life Insurance Company or their representative(s) any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Employee _____ Date Signed _____