Regence BlueCross BlueShield of Utah | Regence ValueCare | Regence HealthWise

Independent Licensees of the Blue Cross and Blue Shield Association

Attn: Membership #4
P.O. Box 30270
Salt Lake City, Utah
84130-0270

GROUP HEALTH QUESTIONNAIRE

MUST BE COMPLETED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS INCLUDING ALL WHO ARE WAIVING COVERAGE

AN INCOMPLETE QUESTIONNAIRE WILL BE RETURNED

Name of Employer s Group ______________________________

Name	Date of Birth	Height	Weight	Social Security Number
Employee :				
Spouse:				
Dependent Child:				
Dependent Child:				
Dependent Child:				
Dependent Child:				

Note: Attach information on additional children

Complete the following information for all family members (whether or not they are applying for coverage). Consult with them to ensure that the information you provide is true, accurate and complete. **You cannot be denied coverage on the basis of any health history that you provide which is true, accurate and complete to the best of your knowledge.**

1. Have you or any listed family members EVER experienced problems or been diagnosed with or been treated for any of the following:

		Yes	No
a.	tumor?	☐	☐
b.	cancer or leukemia?	☐	☐
c.	heart, blood or blood vessels?	☐	☐
d.	lupus, multiple sclerosis, arthritis or gout?	☐	☐
e.	diabetes?	☐	☐
f.	liver, gallbladder or thyroid?	☐	☐
g.	lungs?	☐	☐
h.	dizziness, blackout, convulsions, loss of consciousness or epilepsy?	☐	☐
i.	back pain or other back problems?	☐	☐
j.	sexually transmitted disease?	☐	☐
k.	congenital or physical disorder?	☐	☐
l.	brain or nervous system?	☐	☐
m.	stroke?	☐	☐
n.	lymph system?	☐	☐
o.	immune system?	☐	☐
p.	colitis?	☐	☐
q.	ulcer?	☐	☐
r.	sleep disorders?	☐	☐
s.	transplant(s)?	☐	☐

2. Within the LAST FIVE YEARS, have you or any listed family members experienced problems or been diagnosed with or been treated for any of the following:

		Yes	No
a.	high blood pressure?	☐	☐
b.	bones, joints or muscular system?	☐	☐
c.	intestines, stomach or pancreas?	☐	☐
d.	male or female organs (including but not limited to prostate gland or breast(s))?	☐	☐
e.	mental illness, emotional disorder, anxiety, depression, chemical imbalance or an eating disorder?	☐	☐
f.	alcohol or drug dependency or illegal drug use?	☐	☐
g.	kidney or urinary system?	☐	☐
h.	severe headache?	☐	☐
i.	glands or hormone system?	☐	☐
j.	anemia?	☐	☐
k.	asthma?	☐	☐
l.	infertility?	☐	☐

3. Have you or any dependent ever been told that treatment may be required in the future? Yes ☐ No ☐

4. Are you or any dependent currently using any prescription medications? **(please list specific prescriptions below)** Yes ☐ No ☐

5. Do you or any dependent have or suspect any conditions, symptoms or problems (physical or mental) not otherwise mentioned? Yes ☐ No ☐

6. Are you or any family member **(either applying for or waiving coverage)** currently pregnant? Yes ☐ No ☐

If yes, what is the expected date of delivery?___/___/___

If yes, are you expecting multiple births? Yes ☐ No ☐

If yes, are difficulties, problems or complications anticipated with the pregnancy, delivery or newborn child? Yes ☐ No ☐

7. Have any difficulties, problems or complications been experienced with prior pregnancies, deliveries or newborn children? Yes ☐ No ☐

8. FOR EACH QUESTION 1 THROUGH 7 ABOVE ANSWERED "YES," PLEASE COMPLETE THE FOLLOWING: **(more space provided on back)**

Item # & Letter	Patient's First Name	List condition, disorder, disease, problem, treatment, medication and degree of recovery	Was Patient Hospitalized? Yes	No	Dates of Care First	Last	Actual or Expected Cost of Care
			☐	☐			
			☐	☐			
			☐	☐			

I certify that I have consulted all family members (whether applying for or waiving coverage) about their health history and that the above information is true, accurate and complete to the best of my knowledge. I acknowledge that any coverage issued by Regence BlueCross BlueShield of Utah, Regence ValueCare and/or Regence HealthWise (hereinafter referred to as "the Plan") will be issued in reliance upon the truth, accuracy and completeness of this information, **but understand that coverage cannot be denied on the basis of any health history that I provide which is, to the best of my knowledge, true, accurate and complete.** Should any information provided by me in this questionnaire not be true, accurate and complete to the best of my knowledge, the Plan shall have the right to declare my contract null and void in accordance with applicable provisions of Utah state law.

I hereby authorize any health-care professional or other person or entity to release to the Plan any record, document or other information in connection with any inquiry or investigation into the truth, accuracy or completeness of the information I have provided herein. I further agree to execute releases requested by the Plan for medical and other records and agree that the Plan may cancel my coverage retroactive to its original effective date if I refuse to provide such a release within thirty (30) days after request by the Plan.

I understand and agree that this and all other documents submitted by me remain the exclusive property of the Plan.

Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan. The Plan shall bear the costs of arbitration, filing fees, administrative fees and arbitrator fees. Other expenses of arbitration, including, but not limited to attorney fees, expenses of discovery, witnesses, stenographer, translators and similar expenses, will be borne by the party incurring those expenses. Any decision reached by arbitration shall be binding upon both myself and the Plan. The arbitration award may include attorney's fees, if allowed by state law, and may be entered as a judgment in any court of proper jurisdiction.

I have the option of returning this form to my employer, or I may mail it directly to Regence BlueCross BlueShield of Utah, Membership Department, P.O. Box 30270, Salt Lake City, UT 84130-0270.

_______________________ Employee's Signature

_______________________ Date Signed

Form No. BHV03230-011-GHQ Rev. 09/05

8. (continued) FOR EACH QUESTION 1 THROUGH 7 ANSWERED "YES," PLEASE COMPLETE THE FOLLOWING:

Item # & Letter	Patient's First Name	List condition, disorder, disease, problem, treatment, medication and degree of recovery	Was Patient Hospitalized?		Dates of Care		Actual or Expected Cost of Care
			Yes	No	First	Last	
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