

## Individual Health Questionnaire for Employees of Large Employer Groups (including COBRA participants)

Complete this form using black ink only.

Employee Name \_\_\_\_\_ Employer Group Name \_\_\_\_\_

Please explain any "YES" answers to questions 1 through 8 in the DETAILS TABLE below.	
1. Have you or your dependents incurred medical and/or hospital expenses of \$5,000 or more within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently unable to perform your job duties full time because of illness, injury, mental disorder, or physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you or your dependents confined at home, in a hospital, or in another treatment facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you or your dependents currently undergoing continuing treatment for an illness, injury, mental disorder, or physical disability for which expenses are \$200 per month or \$2,500 per year (including doctor visits, medications, special therapy, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you or your dependents currently pregnant? If yes, what is the expected due date? _____ If yes, are there any expected complications or risks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past five years, have you or your dependents been diagnosed or received treatment or advice from a physician for cancer, heart disease or disorder, lung disease or respiratory disorder, stroke, kidney/urinary disorders, liver disorder, neurological disorders, skin disease, diabetes, arthritis, back/spine/or joint disorder, brain disorder, AIDS/ARC (AIDS related conditions), other immune system disorder, alcohol/drug or substance abuse, mental health, or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Will you or your dependents require hospitalization or surgery in the next 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you or your dependents been advised to have a surgical operation that has not yet been performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**DETAILS TABLE: Please provide specific details below to any question answered "YES" above.**  
Use page 2 if necessary.

Question #	Relation to Employee (self/spouse/child)	Description of Problem, Condition, Treatment, and Outcome	Medications	Last Date Treated	Still Under Treatment?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

I understand Rocky Mountain Health Plans has the right to terminate coverage and deny benefits if any information on this health questionnaire or as otherwise provided by the undersigned for enrollment purposes is false, incomplete, or misleading in any material respect.

Employee Signature: _____	Date: _____
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