

## Health Disclosures

**For each person** applying for coverage, have they seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following within the last 5 years.

- |    | <b>Yes</b>               | <b>No</b>                |  |
|----|--------------------------|--------------------------|--|
| 1. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for any of the following conditions: cancer, heart disease (including Bypass), Heart Attack, Heart Surgery, or Stroke?                                  |
| 2. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage in the past 5 years been home bound or incapacitated or incapable of self-support due to a medical condition?   |
| 3. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for covered, been under the care of a doctor currently or in the past 5 years for Autoimmune or blood disease i.e., Lupus MS, Anemia, AIDS, HIV, Hemophilia, IBS, Crohn's?   |
| 4. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for Organ Failure or Organ Transplant for Kidney, Liver, Lung, Heart and or any form of organ support i.e., dialysis?                                   |
| 5. | <input type="checkbox"/> | <input type="checkbox"/> | Are you or any of your dependents applying for coverage currently pregnant or expecting?   |
| 6. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, currently or in the past 5 years been hospitalized, excluding routine childbirth?  |
| 7. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for respiratory disorders, Emphysema, Chronic Bronchitis, COPD or Chronic Pneumonia?  |
| 8. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for musculoskeletal disorders i.e. Back Disorders, Muscular Dystrophy, Cerebral Palsy, Dermatomyositis, Compartment Syndrome, Sciatica or Osteoporosis? |
| 9. | <input type="checkbox"/> | <input type="checkbox"/> | Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for substance abuse or substance dependency?  |

10.   Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years as a Type 1 Diabetic?

11.   Have you or any of your dependents applying for coverage, been under the care of a doctor currently or in the past 5 years for a previous major surgery? Or have an upcoming planned surgery?