HEALTH INFORMATION QUESTIONS

Employer name_____

Employee	Sex: ☐ Male ☐ Female	Birthdate (mo/day/year)	Age	Height	Weight
Spouse	☐ Wife ☐ Husband				
Dependent Children	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				
	☐ Son ☐ Daughter				

1. Have you or any eligible dependent(s) ever had, been told you had, or been treated for any of the following:

a.	Heart/Circulatory Disorder?	☐ Yes ☐ No	j.	Liver Disorder?	☐ Yes ☐ No
b.	High Blood Pressure?	☐ Yes ☐ No	k.	Gland Disorder?	☐ Yes ☐ No
c.	Mental/Nervous, Emotional Disorders?	☐ Yes ☐ No	l.	Diabetes?	☐ Yes ☐ No
d.	Alcoholism and/or Nerve Disorders?	☐ Yes ☐ No	m.	Developmental Disorder?	☐ Yes ☐ No
e.	Stomach and/or Intestinal Disorder?	☐ Yes ☐ No	n.	Epilepsy, Seizures?	☐ Yes ☐ No
f.	Multiple Sclerosis or Nerve Disorder?	☐ Yes ☐ No	o.	Lung, Respiratory Disorder?	☐ Yes ☐ No
g.	Stroke/Paralysis?	☐ Yes ☐ No	p.	Bone, Joint, Muscle Disorder?	☐ Yes ☐ No
h.	Cancer, Tumors?	☐ Yes ☐ No	q.	Severe Accident or Injury?	☐ Yes ☐ No
i.	Kidney Disorder?	☐ Yes ☐ No	r.	Blood Disorder?	☐ Yes ☐ No

2. Are you or any eligible dependent(s) currently receiving or recommended to receive medication or treatment? ☐ Yes ☐ No

3. Are you or any eligible dependent(s) currently pregnant? ☐ Yes ☐ No

4. Have you or any eligible dependent(s) ever:

a.	Had an electrocardiogram, x-ray, or other special test?	☐ Yes ☐ No
b.	Consulted, been treated or examined by any physician or practitioner during the past 5 years for any reason not mentioned previously?	☐ Yes ☐ No
c.	Have had a surgery or advised to have a surgery in the past 5 years?	☐ Yes ☐ No
d.	Been declined or due to a health condition, received higher rates or had special conditions applied for Life, Major Medical, or Accident and Sickness Insurance?	☐ Yes ☐ No
e.	Been confined to a hospital, sanitarium, or similar institution in the last 5 years?	☐ Yes ☐ No

If any of the above questions is answered YES, on the reverse side state: Question number, name of person, detail of illness or accident, cost of expenses, date last treated for condition, the name of the physician and the city where treated.

5. Do you or any eligible dependent(s) have other health insurance in force with another company?

Name of person:_____Company:_____ Amount/Type of Coverage_____

Name of person:_____Company:_____ Amount/Type of Coverage_____

Name of person:_____Company:_____ Amount/Type of Coverage_____

Question Number	Name of Person	Details/Diagnosis of Illness or Accident	Total of Expenses in the Past 5 Years	Date Last Treated for Condition	Full Name and City and Phone Number for Doctor(s), Hospital(s) Where Treated

I authorize and direct any licensed physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my dependents' health to provide any such information to Valenz Health or any agent or administrator acting on its behalf. By my signature below, **I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.**

I understand that I have the right to receive a copy of this authorization upon request. A copy, image or facsimile of this authorization shall be as valid as the original. This authorization is valid for twelve months from the date signed. I understand that information about my health may be released as required or permitted by law. I have a right to revoke this authorization in writing, by sending a written request to Valenz Health, at 300 North Meridian Street, Ste 1710 Indianapolis, IN 46204, Attention: Underwriting. I acknowledge that upon such revocation, information about my health may be continued to be used for treatment, payment and health care operations; and such revocation is not effective to the extent Valenz Health has relied on the use or disclosure of my health information.

I hereby represent that I have read all statements, questions and responses in this Health Information Questions form (or they have been read to me) and I understand them; and my responses are true, accurate, complete and correctly recorded in all respects. The conditions and health history of me and members of my family are as stated above.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD OR DECEIVE ANY INSURER OR PERSON SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING FALSE INFORMATION OR A DEFECTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

Waiver of health coverage

I decline enrollment at this time because:

- ☐ I have other medical coverage
- ☐ I do not wish to enroll in any type of medical coverage at this time

Signature of Applicant_____

Signed at City_____ **State**_____ **Date**_____