aetna™ Medical Questionnaire

Instructions: You must complete this health questionnaire in full. If you do not, we will return it to you, and that can delay its processing. You alone are responsible for its accuracy and completeness. **If you plan to waive coverage, please complete sections A and B.**

Employer name	Effective date

COBRA for: ☐ Employee ☐ Dependent **Length of continuation:** ☐ 18 ☐ 36 ☐ Other _____ **Original qualifying event date** _____ **Qualifying event** _____

A. Employee information

Last name, first name, middle initial	City, state	ZIP code	Date of hire

Number of hours worked a week _____ **Check one:** ☐ Full time ☐ 1099 ☐ Seasonal ☐ COBRA ☐ Part time ☐ Retired ☐ Temporary ☐ Union

Employee acknowledgement: I certify that all information and statements on this enrollment form are true and complete to the best of my knowledge. I have authority to make statements on behalf of any dependents listed on this form. I understand if I commit fraud or intentionally misrepresent material facts, coverage can be cancelled, or rates can be increased back to the effective date. I agree that my employer or its agent may send this form to Aetna.

Please sign here ONLY if you plan to enroll for coverage for yourself and / or dependents.

X Employee signature _____ **Date** *(Month/Day/Year)* _____

B. Decline / waive – *To be completed if eligible employee and / or their eligible family members do not plan to enroll for coverage.*

Medical coverage declined for:
☐ Myself ☐ Spouse / civil union / domestic partner ☐ Children

Please sign here ONLY if you plan to decline coverage for yourself and / or dependents.

X Employee signature _____ **Date** *(Month/Day/Year)* _____

C. Individuals enrolling – List individuals who plan to enroll for coverage. If more space is needed check here ☐ and use a separate sheet of paper.

	Last name, first name, middle initial	Sex (M/F)	Birthdate (MM/DD/YYYY)	Height	Weight	Tobacco or nicotine use (including E-cigarette devices)
1	☐ Employee					☐ Yes ☐ No
2	☐ Spouse ☐ Civil union ☐ Domestic partner					☐ Yes ☐ No
3	☐ Child ☐ Stepchild ☐ Other					☐ Yes ☐ No
4	☐ Child ☐ Stepchild ☐ Other					☐ Yes ☐ No
5	☐ Child ☐ Stepchild ☐ Other					☐ Yes ☐ No

D. Health questionnaire – Complete for all individuals who plan to enroll for coverage.

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any health care professionals during the last five (5) years for any illness, injury or health condition in any of the categories listed below? If "yes," please check the box that most appropriately describes the condition(s) and explain fully below (pages 3 and 4).

1. Cancer / tumor / cyst ☐ **Yes** ☐ **No**

☐ Brain ☐ Breast ☐ Esophagus ☐ Stomach ☐ Colon ☐ Leukemia ☐ Lymphoma ☐ Multiple myeloma ☐ Kidney ☐ Liver ☐ Lung ☐ Melanoma ☐ Pancreas ☐ Prostate
☐ Testicular ☐ Cervical ☐ Ovarian ☐ Uterine ☐ Throat ☐ Thyroid ☐ Other cancer (type / location _____) ☐ Non-malignant tumor (type / location _____)
Diagnosis date _____ **Cancer stage (0-4)** _____ **(if known) Cancer category (In situ, localized, regional, distant)** _____ **(if known)**
Treatment: ☐ **Surgery date** _____ ☐ **Chemo timeframe** _____ ☐ **Radiation timeframe** _____
☐ **Remission** ☐ Yes ☐ No **If yes, provide date of remission** _____

2. Heart / vascular ☐ **Yes** ☐ **No**

☐ Aneurysm (location _____) ☐ Blocked arteries (e.g., carotid, heart, abdomen, legs) ☐ Heart attack ☐ Heart valve disorder ☐ Congestive heart failure ☐ Cardiomyopathy
☐ Irregular or abnormal heart rhythm ☐ Stroke ☐ Vasculitis (type _____) ☐ Bypass / angioplasty / stent (location _____) ☐ Pacemaker or cardiac defibrillator
☐ Other (specify details below)

3. Blood / clotting disorder ☐ **Yes** ☐ **No**

☐ Hemophilia (specify type below) ☐ Anemia (specify type below; e.g., sickle cell, hemolytic, aplastic) ☐ Blood clots ☐ Other (specify details below)

4. Reproductive / Gynecological ☐ **Yes** ☐ **No**

☐ Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____ , if multiples # ____, any complications _____)
☐ Intending to adopt ☐ Infertility ☐ Other Gynecological conditions (specify details below)

5. Gastrointestinal / endocrine ☐ **Yes** ☐ **No**

☐ Diabetes ☐ Crohn's / ulcerative colitis ☐ Autoimmune hepatitis ☐ Hepatitis B (specify below if acute or chronic) ☐ Hepatitis C (if cured, when did treatment end? _____) ☐ Cirrhosis
☐ Pancreatitis ☐ Growth disorder ☐ Adrenal, pituitary, thyroid gland disorder (specify type below) ☐ Other disorders of the gallbladder, stomach, pancreas, liver, colon (specify type below)

6. Brain / neurological ☐ **Yes** ☐ **No**

☐ Amyotrophic lateral sclerosis ☐ Cerebral palsy ☐ Neuropathy / polyneuropathy ☐ Multiple sclerosis ☐ Myasthenia gravis ☐ Muscular dystrophy ☐ Brain and / or spinal cord disorder or injury
☐ Paralysis, quadriplegia, paraplegia ☐ Other (specify details below)

7. Immune / dermatology ☐ **Yes** ☐ **No**

☐ HIV or AIDS ☐ Immunodeficiency disorder ☐ Connective tissue disorder (specify type below; e.g., lupus, scleroderma) ☐ Hereditary angioedema
☐ Skin disorder (specify type below; e.g., psoriasis, eczema, ulcers, infections) ☐ Other (specify details below)

8. Lung / respiratory ☐ **Yes** ☐ **No**

☐ Cystic fibrosis ☐ COPD, chronic bronchitis, emphysema ☐ Pulmonary hypertension ☐ Pulmonary fibrosis ☐ Other (specify type below; e.g., asthma, sarcoidosis, etc.)

9. Urinary / kidney ☐ **Yes** ☐ **No**

☐ Kidney disease / disorder (specify type below) ☐ Kidney failure ☐ Dialysis: date started _____ ☐ Dialysis possible within the next 18 months ☐ Bladder disorder
☐ Prostate disorder ☐ Other (specify details below)

10. Musculoskeletal ☐ **Yes** ☐ **No**

☐ Rheumatoid or psoriatic arthritis (specify type below) ☐ Disorder of the back / neck / spine ☐ Disorder of the joints (specify location; e.g., hips, knees, shoulders) ☐ Chronic pain disorder
☐ Osteomyelitis ☐ Amputation ☐ Other (specify details below)

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D. Health questionnaire *(Continued)*

11. Mental health / substance abuse ☐ **Yes** ☐ **No**

☐ Alcohol and / or drug abuse (specify type below) ☐ Eating disorder ☐ Anxiety / depression ☐ Bipolar disorder ☐ Schizophrenia ☐ Suicide attempt ☐ Oppositional defiant / conduct disorder
☐ Autism ☐ ABA therapy ☐ Other (specify details below)

12. Transplant ☐ **Yes** ☐ **No**

☐ Organ or bone marrow / stem cell transplant already performed (date _____) ☐ Future transplant planned / scheduled (date _____)
☐ Transplant discussed / recommended / possible within the next 18 months ☐ Transplant complications ☐ Other (specify details below)

13. Birth / inherited conditions ☐ **Yes** ☐ **No**

☐ Premature birth (gestational age: ____ # weeks) ☐ Congenital birth defect ☐ Genetic / metabolic disorder ☐ Any syndrome (specify details below) ☐ Other (specify details below)

14. Eyes / ears / nose / throat ☐ **Yes** ☐ **No**

☐ Acoustic neuroma ☐ Cataracts ☐ Cleft lip / palate ☐ Deviated septum ☐ Glaucoma ☐ Retinopathy ☐ Chronic ear infections ☐ Chronic sinusitis ☐ Other (specify details below)

15. Medications ☐ **Yes** ☐ **No**

Current medications:
Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)
Medications taken within the past 12 months:
Person _____ # of meds ____ Person _____ # of meds ____ (list medication name(s) and diagnosis below)

16. Incapacitated ☐ **Yes** ☐ **No**

Reason: ☐ Disabled ☐ Handicapped ☐ Congenital disorder ☐ Other (specify details below)

17. Other ☐ **Yes** ☐ **No** (specify details below)

☐ Hospitalizations in the past 5 years ☐ Future surgeries or hospitalizations discussed / planned / recommended / scheduled or possible within the next 18 months
☐ Other conditions not addressed elsewhere in the application

Provide details below for all "yes" answers indicated above. If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.

Ques. No.	Enrollee name	Conditions / diagnosis	Date diagnosed	Treatment (include surgery, hospitalized, durable medical equipment / supplies, etc.)	Medication names (include those taken orally, injected, infused, topically, nasally, inhaled, etc.)	Dates treated	Is treatment ongoing? If yes, provide details of any current OR future treatment.

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D. Health questionnaire *(Continued)*

Provide details below for all "yes" answers indicated above. If additional space is needed, attach a separate sheet. All attachments must be signed and dated by the applicant.							
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