HEALTH QUESTIONS

Please answer the following questions. If you answer "YES" to any questions, please provide details in REMARKS below.
If you are applying for dependent coverage, please answer all questions for your eligible dependents.

Applicant: Height _____ Weight _____ **Spouse:** Height _____ Weight _____

	Yes	No
1. Have you or your dependents gained or lost 10 or more pounds during the past 12 months? If "Yes," how much _____	☐	☐
2. Have you or your dependents within the past 5 years:		
a) Received or been advised to receive any medication, treatment, surgery, therapy, testing, observation, or consultation by a physician, surgeon or other health care provider (including psychologist, counselor, dentist, chiropractor, osteopath, etc.) in any clinic, hospital, sanitarium, health resort or any other health related facility?	☐	☐
b) Used any illegal drugs?	☐	☐
3. In the past 5 years, have you or your dependents ever had, been treated for or been advised to seek treatment for persistent cough, fatigue or swollen glands, pneumonia, chest discomfort, muscle weakness, unexplained weight loss of ten pounds or more, patches in mouth, skin lesions, prolonged night sweats, visual disturbance or recurring diarrhea, fever or infection?	☐	☐
4. Are you or your dependents pregnant?	☐	☐
5. Have you or your dependents used tobacco, in any form in the past 12 months?	☐	☐
6. Have you or your dependents ever had, been medically diagnosed, treated or been advised to seek treatment for: arthritis; back, neck or joint disorder; asthma; emphysema or lung disorder; cancer or tumors; diabetes; alcohol, cocaine or drug abuse; high blood pressure; stroke or heart disease or disorder; depression; psychological counseling; mental, nervous or eating disorder; seizures; acquired immunodeficiency syndrome (AIDS) within the past 5 years? "Disorder" is defined as a disease, illness, injury and/or condition differing in any way from the usual or normal state and/or structure.	☐	☐

Name, address and telephone no. of personal physician _____

REMARKS-If you answered "YES" to any health question above, please provide details below.

Ques. No.	First Name	Description of illness, injury, or pregnancy, medication and treatment	Duration (dates) & no. of episodes	Residual effects/ results	Name and address of attending physician or hospital (*include zip*)

IMPORTANT NOTICE TO APPLICANTS - PLEASE READ CAREFULLY

MY SIGNATURE ON THIS APPLICATION CERTIFIES THAT I:

1) Apply for the coverages designated for which I am eligible under my employer's plan with Fortis Benefits Insurance Company. 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Fortis Benefits Insurance Company. For Dental coverage, I understand that I will not be entitled to benefits until the expiration of the Late Entrant Limitation period specified in the policy. 3) Authorize any required deductions from my earnings. 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. 5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 6) Understand that I must be actively at work the number of hours specified in my policy/ participation agreement to remain insured. 7) Have read, understood and received a copy of this application and the NOTICE REGARDING THE MEDICAL INFORMATION BUREAU, INSURANCE INFORMATION PRACTICES AND AUTHORIZATION TO OBTAIN AND FURNISH INFORMATION. 8) Understand that I have the right to select any dental care provider of my choice. 9) Understand that the dental plan includes a pre-estimate provision that will advise me in advance of the benefits I may be eligible for if the procedure is performed.

For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

AUTHORIZATION TO RELEASE INFORMATION: For underwriting and claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, pharmacy, insurance company, consumer reporting agency, employer, Medical Information Bureau to give Fortis Benefits or its reinsurers ALL INFORMATION on my behalf, including findings on medical care, dental care, alcohol or drug abuse information, psychiatric or psychological care or examination, or surgery, as they apply to me or my dependents who are to be insured. I give my permission to Fortis Benefits or its reinsurers to release any information to other life insurance companies as I may come in contact with.

I know that I have a right to a copy of this authorization. A photocopy of this authorization will be as valid as the original. This authorization will be valid for the term of coverage of the policy if health insurance or the duration of the claim for non-health insurance.

Employee's signature _____ Date _____

Spouse's signature (*if spousal coverage*) _____ Date _____

ALL Kaiser authorizations MUST have the patients Kaiser ID# on it

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Kaiser Foundation Hospitals
The Permanente Medical Group, Inc.

Patient must complete ALL marked areas.

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

IMPRINT AREA

I understand that Kaiser Permanente will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize: _____
Name of Disclosing Party

_____
Address

_____
City State ZIP

to disclose to: _____
Name of Recipient

_____
Address

_____
City State ZIP

records and information pertaining to:

_____ _____ _____
Name of Member/Patient (List Other Names Used) Medical Record Number Date of Birth

_____ _____
Address Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here _____ (Date).

REVOCATION: This authorization is also subject to written revocation by the member/patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box, initial and/or sign to specify which type of information is to be disclosed.

- ☒ **MEDICAL INFORMATION** _____ (Initial)
- ☐ **PSYCHIATRIC INFORMATION**
- ☐ **DRUG/ALCOHOL INFORMATION**
- ☐ **RESULTS OF AN HIV TEST**
- ☐ **GENETIC RECORDS**
- ☐ **OTHER HEALTH INFORMATION** _____ (Initial) (specify below)

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

_____ _____
Signature Date

Specify the records to be disclosed: _____

The recipient may use the health information authorized on this form for the following purposes:

_____ _____

A copy of this authorization is as valid as the original.
Member/Patient has a right to a copy of this authorization.

_____ _____ _____
Date Signature If Signed by Other than Member/Patient, Indicate Relationship