SELF-FUNDING HEALTH HISTORY QUESTIONNAIRE

Employee Information

Employer Name ____

Name of Employee ______________________________ Job Title ______________________

Address, City, State, Zip ______________________________________ Phone No. ____________

Employment Status: Full-Time ___ Part-Time ___ Number of Hours Per Week ______ Date of Hire ____________

Health Information

Name (include all family members to be covered)	Relationship	Sex	DOB	State	Height	Weight
(1)		M F				
(2)		M F				
(3)		M F				
(4)		M F				

Has Employee or any Family Member applying for coverage:
(for "Yes" answers, provide details below or on the back of this form and list question number)

1. Within the past 3 years consulted any doctors, therapists, counselors, or health care providers of any kind, or received any treatment, other than routine checkups or minor illnesses? Yes ___ No ___
2. Within the past 3 years had any loss of weight; been in a hospital, sanitarium, or institution for observation or treatment; had electrocardiograms, x-rays, blood studies, or other diagnostic test? Yes ___ No ___
3. Ever had or been treated for any of the following:

   a. chest pain; disease of heart, arteries or blood vessels; high or low blood pressure; stroke? Yes ___ No ___
   b. nervous, mental, or emotional disorder; convulsions; epilepsy; unconsciousness? Yes ___ No ___
   c. asthma or other disease of lungs or respiratory organs? Yes ___ No ___
   d. kidney stones; disease of kidney, bladder, male or female organs; infertility? Yes ___ No ___
   e. cancer and/or cancerous tumor (state type, part of body)? Yes ___ No ___
   f. diabetes; liver or thyroid disease; enlargement of the lymph nodes; blood disorder? Yes ___ No ___
   g. stomach, gall bladder, intestinal or colon disorders? Yes ___ No ___
   h. rheumatoid arthritis or back disorders? Yes ___ No ___
   i. phlebitis, paralysis, or any other physical impairment or deformity? Yes ___ No ___
   j. alcoholism or drug habit, or been a member of Alcoholics Anonymous? Yes ___ No ___
   k. AIDS or an AIDS-related complex; other immune system disorder? Yes ___ No ___

Please give details below for any questions checked "Yes." Use reverse side for additional health information.

Question No.	Name of Person	Details of Yes Answer	Onset (Mo/Yr)	Duration	Results/Findings	Full Name and Address of Attending Physician

Authorization to Obtain and Disclose Information

I authorize any physician, medical practitioner, hospital, medical clinic, other provider of health care, any insurance company, the MIB Inc., any consumer reporting agency or employer, to disclose to this company or its authorized medical, underwriting and claims representative all information and records relating to a diagnosis, treatment, medical history, physical and mental condition and evaluation, or any other information relating to me or my dependents. Such records and information may be used by this company now or in the future in connection with the underwriting of my application for insurance, the reinstatement, renewal or continuation of any policy issued, and any claims on any policy issued. I understand that any information obtained will not be released by this company to any person or organization except its reinsures, the MIB Inc., other persons or other organizations performing business or legal services in connection with my application or policy, or as may be required by law, or as I may further authorize. Information obtained from the MIB, Inc. will not be released except as may be required by law. A photocopy of this authorization shall be as valid as the original. For the purpose of collecting information in connections with a claim for benefits under the coverage resulting from this application, this authorization remains valid for the term of coverage if the claim is for the health insurance benefit, or the duration of the claims if the claim is not for health insurance benefit. For all other purposes, this authorization remains valid for 30 months from this date. I have the rights to receive a copy of this authorization.

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Employee's Signature Date