EMPLOYEE INFORMATION:

Last Name:	First Name:	
Email Address:	**Date of Birth:**	**Date of Hire:**

DEPENDENT INFORMATION (Please only put those who will be applying for coverage):

Spouse's Name:	Date of Birth:	Gender:		Height:	Weight:
		Male	Female		
Child's Name:	**Date of Birth:**	**Gender:**		**Height:**	**Weight:**
		Male	Female		
Child's Name:	**Date of Birth:**	**Gender:**		**Height:**	**Weight:**
		Male	Female		
Child's Name:	**Date of Birth:**	**Gender:**		**Height:**	**Weight:**
		Male	Female		

Please answer the following Health Questions: Should any answer be yes, please provide details in the bottom section.

Question		
Within the past 5 yrs, have you or any dependent had or been treated for heart disorder, high blood pressure, stroke, cancer, tumor, diabetes, kidney or liver disease, an immune deficiency disorder, AIDS, AIDS-related complex (ARC), respiratory disorder, or any mental nervous system disorder?	Yes	No
Within the past 5 yrs, have you or any dependent had or been treated for arthritis, back, bone or joint disorders?	Yes	No
Within the past 5 yrs, have you or any dependent had or been treated for seizures, convulsions, fainting spells, or epilepsy?	Yes	No
Within the past 5 yrs, have you or any dependent had or been treated for digestive system disorder, ulcer, liver, colon, or rectal disorder?	Yes	No
In the past 12 months, have you or any dependent incurred more than $5,000 in medical expenses?	Yes	No
Are you or a dependent currently pregnant? If yes, due date? ______________________	Yes	No
Within the past 5 years, have you or any dependent been confined to a hospital or similar facility?	Yes	No
Within the past 12 months, have you or any dependent been prescribed or taken any prescription medications?	Yes	No

Person Treated:	Type of Illness/Injury/Rx	Treatment	Recovered or Ongoing?	If Ongoing, when were you last seen?

Employee Signature:		Dated: