Medical Profile

* = Required

My Profile

Last Name: *	First Name, M.I. *		Date of Birth *	Sex *	SSN *	Height *	Weight *
			/ /		- -	ft. in.	lbs.

Home Address *	City *	State *	Zip code *	County

Home Telephone (xxx) xxx-xxxx *	Cell Phone (xxx) xxx-xxxx *	Work Phone (xxx) xxx-xxxx *	eMail Address

Occupation *	Full Time Hire Date *	Full-Time or Part-Time? *	Hours *	Income Reported By *	Yearly Salary *
	/ /			W2 1099 K-1	

Are you Disabled? *	If Disabled, Explain:
No Yes	

Are you a Tobacco Product User? *	Currently Pregnant *	Marital Status *
No Light Use Heavy Use	No Yes - Due Date	Married/Domestic Partner Single Divorced

Beneficiaries *(Enter N/A into these fields if you will be waiving Life and Disability products or if you do not have a Contingent Beneficiary)*

Primary Beneficiary First Name *	Primary Beneficiary Last Name *	Primary Beneficiary Relationship *

Contingent Beneficiary First Name *	Contingent Beneficiary Last Name *	Contingent Beneficiary Relationship *

My Dependents *If You have 4+ Dependents, Make Copies of this Page

Dependent #1

Name		Gender	Relationship	SSN	DOB (mm/dd/yyyy)	Disabled	Student?
				- -	/ /		

Height		Weight	Disabled Explanation (If Disabled)	Pregnant Y or N?	Due Date	Tobacco
ft.	in.					

Dependent's Address (if different from yours).

Address	City	State	Zip

Dependent #2

Name		Gender	Relationship	SSN	DOB (mm/dd/yyyy)	Disabled	Student?
				- -	/ /		

Height		Weight	Disabled Explanation (If Disabled)	Pregnant Y or N?	Due Date	Tobacco
ft.	in.					

Dependent's Address (if different from yours).

Address	City	State	Zip

Dependent #3

Name		Gender	Relationship	SSN	DOB (mm/dd/yyyy)	Disabled	Student?
				- -	/ /		

Height		Weight	Disabled Explanation (If Disabled)	Pregnant Y or N?	Due Date	Tobacco
ft.	in.					

Dependent's Address (if different from yours).

Address	City	State	Zip

My Elections

Enter "Elect" or "Waive for Each Benefit

Employee Name	Medical	Dental	Short Term Disability	Long Term Disability	Vision	Life (Basic)

Dependents	Medical	Dental	Vision

Previous and Current Medical Coverage

Have your current Insurance ID card ready for completing the section below.

Medical (For Medicare, see Medicare section below)

Do you or your dependents currently have, or have you had, medical coverage (NOT Medicare) in the past 18 months? * Y or N?

If No - Skip section

Enter Current\Most Recent Coverage Below:

Carrier Name: Phone: Coverage Type:

Effective\Start Date: Renewal\End Date: Policy Type:

Policy Holder Name: Policy Number: If other policy type, specify:

Family members covered by this health coverage:

Complete if you have had any other coverage in the past 18 months

Carrier Name: Phone: Coverage Type:

Effective\Start Date: Renewal\End Date: Policy Type:

Policy Holder Name: Policy Number: If other policy type, specify:

Family members covered by this health coverage:

On the day your new coverage begins, will you or a family member be covered by any other insurance at the same time? *For example a supplemental policy or your spouse is covered on a separate policy.* * Y or N?

If yes, complete the coverage information below:

If No - Skip section

Carrier Name: Phone: Coverage Type:

Effective\Start Date: Renewal\End Date: Policy Type:

Policy Holder Name: Policy Number: If other policy type, specify:

Family members covered by this health coverage:

Complete if you have Continuing Coverage

Carrier Name: Phone: Coverage Type:

Effective\Start Date: Renewal\End Date: Policy Type:

Policy Holder Name: Policy Number: If other policy type, specify:

Family members covered by this health coverage:

Previous and Current Dental Coverage

Dental

Do you or your dependents currently have, or have you had, dental coverage in the past 18 months? * Y or N?

Enter Prior Coverage Below: If No - Skip section

Carrier Name: Phone:

Policy Holder Name: Policy Number:

Effective\Start Date: Renewal\End Date:

Coverage Type: Policy Type:

If other policy type, specify:

Family members covered by this dental coverage:

Complete if you have had any coverage in the past 18 months

Carrier Name: Phone:

Policy Holder Name: Policy Number:

Effective\Start Date: Renewal\End Date:

Coverage Type: Policy Type:

If other policy type, specify:

Family members covered by this dental coverage:

On the day your new coverage begins, will you or a family member be covered by any other dental insurance at the same time? *For example a supplemental policy or your spouse is covered on a separate policy.* * Y or N?

If yes, complete the coverage information below: If No - Skip section

Carrier Name: Phone:

Policy Holder Name: Policy Number:

Effective\Start Date: Renewal\End Date:

Coverage Type: Policy Type:

If other policy type, specify:

Family members covered by this dental coverage:

Within the past 18 months, have you had any individual or group Orthodontia coverage? * Y or N?

Previous and Current Medicare Coverage

Medicare

On the day your new coverage begins, will you be covered by Medicare at the same time? * Y or N?

Medicare ID #

If No - Skip section

Part A effective date: Part B effective date: Part D effective date:

Medicare eligibility reason (check all that apply): ☐ Age ☐ Disability ☐ ESRD\ESRD Onset Date:

Family members covered by this Medicare coverage:

Are any of your dependents covered by Medicare? * Y or N?

Medicare ID #

If No - Skip section

Medicare Holder Name: Relationship:

Part A effective date: Part B effective date: Part D effective date:

Medicare eligibility reason (check all that apply): ☐ Age ☐ Disability ☐ ESRD\ESRD Onset Date:

Family members covered by this Medicare coverage:

Complete if you have had Medicare Coverage in the past 18 Months

Medicare ID #

Medicare Holder Name: Relationship:

Part A effective date: Part B effective date: Part D effective date:

Medicare eligibility reason (check all that apply): ☐ Age ☐ Disability ☐ ESRD\ESRD Onset Date:

Family members covered by this Medicare coverage:

Enter Medical Condition Details

Please enter only 1 medical condition on each form below. If more forms are required please make copies of this page

NOTE:

If you have Diabetes, Elevated Cholesterol, or High Blood Pressure provide at least 1 reading under "Diagnosis/Treatment"

Disease/Condition | Pregnancies MUST be listed as a condition.

Date Diagnosed: * | Date last seen by doctor for this condition: *

Symptoms: *

Physicians Name: * | Physician's Phone:

Treatment Date: From: * To: * * If ongoing condition, enter today's date

Did this condition require surgery or hospitalization: *

Current Needing Surgery: * *(Must List Date(s) Below in Diagnosis Field)*

Have you Fully Recovered: *

Does this condition involve Workers Compensation: * | If Yes, please enter the case number:

Have you visited an Emergency Room for this condition: * | If Yes, please enter the date:

Was informed that future surgery, special tests or treatment may be necessary: * (If Yes, list details below)

Estimated total expenses relating to this condition within past 12 months: *

Currently taking or have taken Prescription Medication or other Medications for this condition: *

Medications: * *(Include prescription medication, Insulin dosage, over-the-counter drugs and herbal preparations)*

Medication Name	Dosage	Frequency	Enter: Currently Taking OR Stopped Taking

Diagnosis/Treatment: *
(Include tests, hospitalization dates, and surgery dates)

Current Status of Condition/Prognosis: *
Example: Controlled, Getting Better, Great!

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* State Specific Questions

My Family's Additional Health Related Questions

Answer the following questions below for both you and all of your dependents *(If None - Leave fields blank)*

Name	
Primary Care Physician	
* Primary Care Physician ID/Office ID **CA Residents ONLY**	
* Primary Dentist Name **CA Residents ONLY**	
* Primary Dentist ID/Office ID **CA Residents ONLY**	
List any medication you are taking not related to a medical condition.	
List any medications that you have stopped using without the approval of a physician or failed to take as directed.	
Explain why the discontinued medications were prescribed.	
* If you have been convicted of a DUI in the last 5 years, please enter dates. **MO,KS,CA Residents Only** Date 1: Date 2: Date 3:	
If you have had individual or group counseling in the last 12 months, please enter frequency of the counseling.	
If you have had counseling, enter the date of last session.(MM/DD/YYYY)	
On what date did you start using tobacco products?	
Describe your daily usage of tobacco products.	
If you have been released from the military for medical reasons, please explain.	
If you have had any life or health insurance declined, postponed or modified, or had a waiver or extra premium added, please explain.	
If you have received payment(s) for disability due to illness or injury, please explain.	
If you have had a change of weight of more than 20 lbs. in the last 12 months, please explain.	

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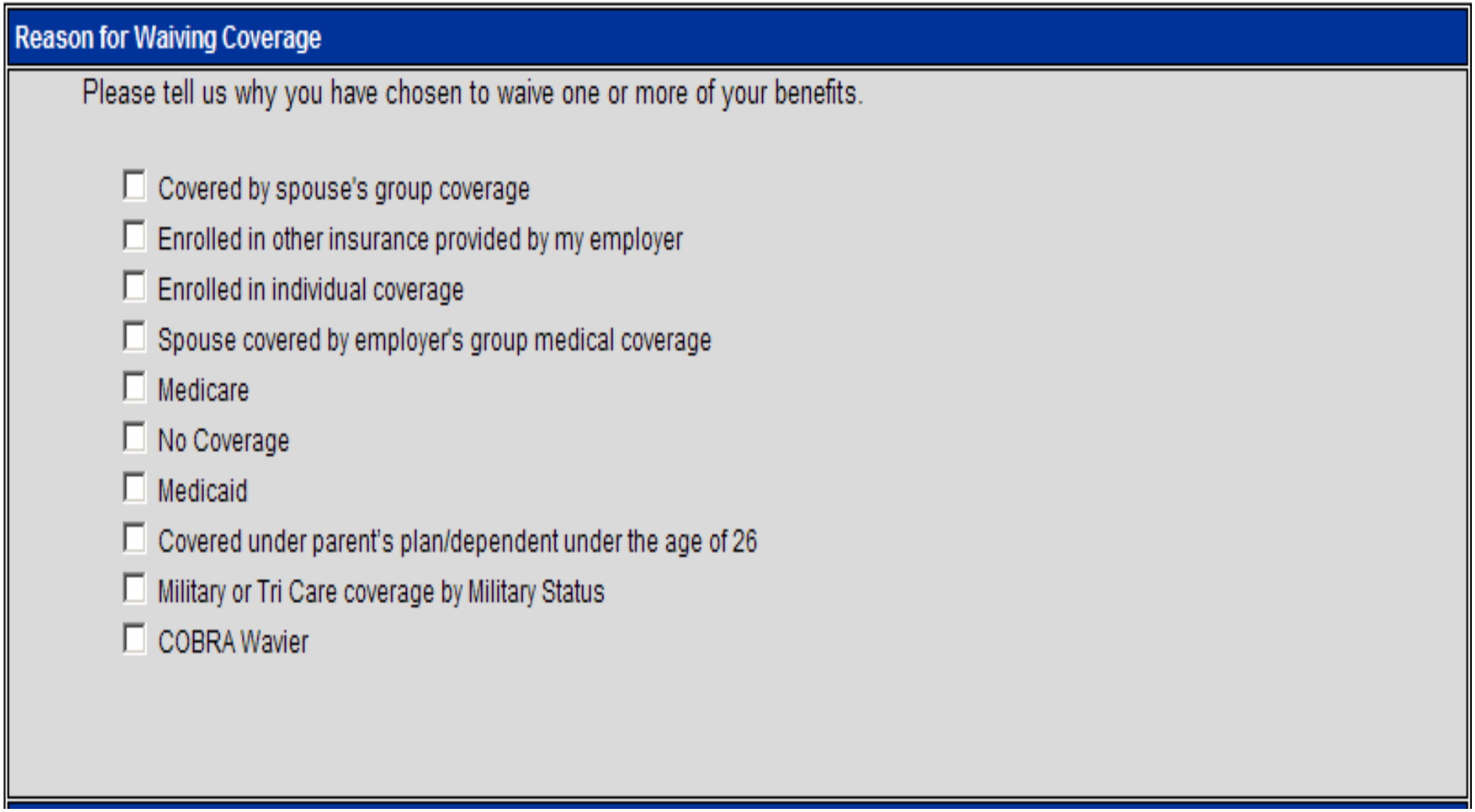
Please fill in one or more of the boxes next to any reasons you have for waiving one or more of the benefits.



Congratulations!

Thank you for completing the

EasyAppsOnline

Medical Profile

Please submit the completed application to the individual that provided it to you.