

# Employee and Family Medical Questionnaire

## Section 1: Employer/Employee Information

Employer Name: \_\_\_\_\_

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height	Weight
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

## Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory <input type="checkbox"/> YES <input type="checkbox"/> NO	D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO	H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> A1. Anemia <input type="checkbox"/> A2. Angina <input type="checkbox"/> A3. Angioplasty/Stent <input type="checkbox"/> A4. Aneurysm <input type="checkbox"/> A5. Blood Clots <input type="checkbox"/> A6. Blood Disorder <input type="checkbox"/> A7. Bypass <input type="checkbox"/> A8. Cardiac Arrhythmia <input type="checkbox"/> A9. Chest Pain <input type="checkbox"/> A10. Congestive Heart Failure <input type="checkbox"/> A11. Coronary Heart Disease <input type="checkbox"/> A12. Heart Murmur <input type="checkbox"/> A13. Hemophilia <input type="checkbox"/> A14. High/Low Blood Pressure <input type="checkbox"/> A15. High Cholesterol <input type="checkbox"/> A16. Pacemaker <input type="checkbox"/> A17. Palpitations <input type="checkbox"/> A18. Sickle Cell Anemia <input type="checkbox"/> A19. Stroke/TIA <input type="checkbox"/> A20. Varicose Veins <input type="checkbox"/> A21. Ventricular Tachycardia <input type="checkbox"/> A22. Other ( _____ )	<input type="checkbox"/> D1. Brain <input type="checkbox"/> D2. Breast <input type="checkbox"/> D3. Colon <input type="checkbox"/> D4. Cyst <input type="checkbox"/> D5. Hodgkin's Disease <input type="checkbox"/> D6. Leukemia <input type="checkbox"/> D7. Liver <input type="checkbox"/> D8. Lung <input type="checkbox"/> D9. Lymphoma <input type="checkbox"/> D10. Melanoma <input type="checkbox"/> D11. Ovarian <input type="checkbox"/> D12. Pituitary <input type="checkbox"/> D13. Prostate <input type="checkbox"/> D14. Stomach <input type="checkbox"/> D15. Testicular <input type="checkbox"/> D16. Thyroid <input type="checkbox"/> D17. Other ( _____ ) <input type="checkbox"/> D18. Stage of Cancer if known _____	<input type="checkbox"/> H1. Bulging/Herniated Disk <input type="checkbox"/> H2. Carpal Tunnel Syndrome <input type="checkbox"/> H3. Fibromyalgia/CFS <input type="checkbox"/> H4. Fractures (Open or Closed) <input type="checkbox"/> H5. Gout <input type="checkbox"/> H6. Joint Replacement (Type: _____ ) <input type="checkbox"/> H7. Knee <input type="checkbox"/> H8. Muscular Dystrophy <input type="checkbox"/> H9. Neck/Back <input type="checkbox"/> H10. Shoulder <input type="checkbox"/> H11. Spina Bifida <input type="checkbox"/> H12. Sprain/Strain <input type="checkbox"/> H13. Other ( _____ )
<b>B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> B1. Acoustic Neuroma <input type="checkbox"/> B2. Cataracts <input type="checkbox"/> B3. Chronic Sinusitis <input type="checkbox"/> B4. Cleft Lip/Palate <input type="checkbox"/> B5. Detached Retina <input type="checkbox"/> B6. Deviated Septum <input type="checkbox"/> B7. Ear Infections <input type="checkbox"/> B8. Glaucoma <input type="checkbox"/> B9. Retinopathy <input type="checkbox"/> B10. Other ( _____ )	<b>E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> E1. Alzheimer's Disease <input type="checkbox"/> E2. Cerebral Palsy <input type="checkbox"/> E3. Epilepsy <input type="checkbox"/> E4. Head Injury <input type="checkbox"/> E5. Migraines <input type="checkbox"/> E6. Multiple Sclerosis <input type="checkbox"/> E7. Neuritis <input type="checkbox"/> E8. Paralysis/Hemiplegia <input type="checkbox"/> E9. Parkinson's Disease <input type="checkbox"/> E10. Seizures/Convulsions <input type="checkbox"/> E11. Other ( _____ )	<b>I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> I1. ADD/ADHD <input type="checkbox"/> I2. Alcoholism <input type="checkbox"/> I3. Anxiety <input type="checkbox"/> I4. Autism <input type="checkbox"/> I5. Bipolar <input type="checkbox"/> I6. Depression <input type="checkbox"/> I7. Drug Abuse <input type="checkbox"/> I8. Eating Disorder <input type="checkbox"/> I9. Schizophrenia <input type="checkbox"/> I10. Suicide Attempt <input type="checkbox"/> I11. Other ( _____ )
<b>C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. AIDS <input type="checkbox"/> C3. HIV+ <input type="checkbox"/> C4. Immuno Deficiency <input type="checkbox"/> C5. Lupus <input type="checkbox"/> C6. Psoriasis <input type="checkbox"/> C7. Scleroderma <input type="checkbox"/> C8. Other ( _____ )	<b>F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> F1. Pending <input type="checkbox"/> F2. On Waiting List <input type="checkbox"/> F3. Completed Transplant <input type="checkbox"/> F4. Bone Marrow <input type="checkbox"/> F5. Stem Cell <input type="checkbox"/> F6. Organ (Type: _____ )	<b>J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> J1. Diabetes controlled by: <input type="checkbox"/> a. Diet <input type="checkbox"/> b. Oral Medication <input type="checkbox"/> c. Insulin <input type="checkbox"/> d. Other ( _____ ) <input type="checkbox"/> J2. Adrenal Glands <input type="checkbox"/> J3. Growth Hormones <input type="checkbox"/> J4. Hyperthyroidism/Hypothyroidism <input type="checkbox"/> J5. Other ( _____ )
	<b>G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis <input type="checkbox"/> G4. Other ( _____ )	<b>K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO</b> <input type="checkbox"/> K1. Breast Disorder <input type="checkbox"/> K2. Endometriosis <input type="checkbox"/> K3. Fibroids <input type="checkbox"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts <input type="checkbox"/> K6. Other ( _____ )

L. Lung/Respiratory	<input type="checkbox"/> YES <input type="checkbox"/> NO	M. Intestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO	N. Liver/Kidney/Urinary	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> L1. Allergies		<input type="checkbox"/> M1. Acid Reflux/GERD		<input type="checkbox"/> N1. Bladder Disorder	
<input type="checkbox"/> L2. Asthma		<input type="checkbox"/> M2. Colitis/IBS		<input type="checkbox"/> N2. Cirrhosis	
<input type="checkbox"/> L3. COPD (On Oxygen? _____)		<input type="checkbox"/> M3. Colon Disorder		<input type="checkbox"/> N3. Gaucher's Disease	
<input type="checkbox"/> L4. Cystic Fibrosis		<input type="checkbox"/> M4. Crohn's Disease		<input type="checkbox"/> N4. Hepatitis (Type: _____)	
<input type="checkbox"/> L5. Emphysema		<input type="checkbox"/> M5. Diverticulitis/Diverticulum		<input type="checkbox"/> N5. Jaundice	
<input type="checkbox"/> L6. Lung Disorder		<input type="checkbox"/> M6. Gallbladder		<input type="checkbox"/> N6. Kidney Disorder	
<input type="checkbox"/> L7. Pneumonia		<input type="checkbox"/> M7. Gastric Bypass		<input type="checkbox"/> N7. Kidney Stones	
<input type="checkbox"/> L8. Sarcoidosis		<input type="checkbox"/> M8. Hiatal Hernia/Reflux		<input type="checkbox"/> N8. Liver Disorder	
<input type="checkbox"/> L9. Sleep Apnea		<input type="checkbox"/> M9. Pancreatitis		<input type="checkbox"/> N9. Polycystic Kidney	
<input type="checkbox"/> L10. Tuberculosis		<input type="checkbox"/> M10. Ulcer		<input type="checkbox"/> N10. Prostate	
<input type="checkbox"/> L11. Valley Fever		<input type="checkbox"/> M11. Ulcerative Colitis		<input type="checkbox"/> N11. Renal Failure	
<input type="checkbox"/> L12. Other (_____)		<input type="checkbox"/> M12. Other (_____)		<input type="checkbox"/> N12. Other (_____)	

Please answer the following questions for yourself and for anyone in your family applying for coverage:

- YES  NO Is anyone currently pregnant or an expectant parent?  
**Due date:** \_\_\_\_\_  
 Yes  No a. Has the pregnancy been confirmed by a physician or practitioner?  
 Yes  No b. Pregnancy complications?  
 Yes  No c. Multiple births expected?
- YES  NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?
- YES  NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?
- YES  NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?  
 abnormal test or physical results  pending test results  
 health condition, illness or injury that may require treatment or surgery  
 tests, treatment or surgery advised  unexplained weight gain/loss or fatigue  
 Worker's Compensation injury or illness  condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

**Section 3: Family Medications**

YES  NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

Employee Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

**L & A Services, Inc.**  
**Notice of Privacy Policy and Insurance Information Practices**

Thank you for trusting us with your insurance needs, your privacy is very important. You provide personal information when you request a quote for insurance, on insurance applications, on insurance claims and other issues relating to your policy. We are very careful to protect your private information. Only when you request service or in activities to maintain and service your account, would private information be shared and only with your insurance company, insurance company affiliated office, agency or any insurance agency or organization that we work with to maintain your account. Otherwise, your private information is not shared, sold or used for any other purpose.

**The following notice describes our policies and practices with regard to collecting and disclosing nonpublic personal information about our customers and former customers.**

**Confidentiality and security of your nonpublic personal information**

We maintain appropriate electronic and procedural safeguards to maintain the confidentiality and security of your nonpublic personal information contained in our records. We restrict access to nonpublic personal information about you, contained in our records, to our associates who need to know that information to provide products and services for you.

**Categories of information that we collect**

We collect nonpublic personal information about you from among the following sources:

- Information that we receive from you on applications and other forms;
- Information about your transactions with our affiliates, others or us;
- Information that we receive from a consumer protective agency;
- Information that we receive when you visit us through the internet.

**Categories of parties to whom we may disclose information**

We may disclose nonpublic personal financial information about you to our affiliates. We may disclose non public personal information about you to nonaffiliated third parties as permitted or required by law to assist with providing you products and service.

**Accuracy of your nonpublic personal information that we possess**

We strive to maintain the accuracy of your information. In order to help us maintain accuracy, you have the right to reasonably access your information. If you believe any of your information in our possession is inaccurate, you may request that we amend, correct or delete the information that you believe to be erroneous. If we concur with your conclusion, we will amend, correct or delete the information in question.

**Changes to our notice of privacy policy and insurance information practices**

We reserve the right to change our privacy practices and information practices. If we make any changes to our policies or practices, we will provide a revised notice as required by applicable law.

## Disclosures

### **In accordance with the National Association of Insurance Commissioner (NAIC) guidelines for consumer disclosure:**

Agents and Brokers generally are paid a sales commission by an insurance carrier for the sale and service of an insurance policy or contract. Commissions may be a one-time payment, may be for the first year only, for a specified period, or may be for the life of the contract. Commissions may be a fixed amount, a percentage of premium, level or graded and may vary based on sales production, client retention, or by other criteria determined by each insurer. Performance based contingent commissions such as sales bonuses, production incentives, contests, trips, prizes, etc. may be offered to the agent or broker by an insurance carrier.

**Our position:** We all expect to be compensated for the work that we do. Like many sales organizations, commissions are how we are paid for our work. Our client's are generally presented with more than one plan option and they choose the plan that is best for their needs based on a balance of cost and benefits. Our job is to help our clients to select the best plan for their needs without regard to how we may be compensated by that carrier. Since we do not sell based on bonuses or additional carrier incentives, any contingent commissions we may receive are co-incidental. L & A's sales reps are employees, are paid salaries and benefits plus bonuses to sell new and to service our in force accounts. Our clients are very important to us. Maintaining active in force policies is the basis of our business. Should you have any questions about this, please let us know.