



Personal Health Questionnaire

Employee Name: _____

Employer Name: _____

Daytime Phone: () - _____

Date of Hire: _____

Email: _____

Preferred Contact: Phone Text Email

Are you planning to enroll in your employer's health insurance plan? Yes No

***** If you selected "No", please select one of the following, then skip the remainder of the form and sign the bottom of p. 2.**

- Covered by Spouse's plan Not Eligible
 Do Not Want Coverage Other Reason (_____)

- If you selected "yes," please complete the rest of this form.
- Answer the following questions for yourself and eligible enrolling family members.
- Include additional sheets for detailed explanations or additional dependents.
- All questions must be answered or the form may not be accepted.

I. Demographic, Build and Tobacco Use

	Relation to Employee	Member Name	Gender (M / F)	Date of Birth (mm/dd/yyyy)	Height		Weight (lbs)	Home Zip Code	Tobacco use in last year? (Yes / No)
					ft.	in.			
1	Employee								
2	Spouse								
3	Child								
4	Child								
5	Child								
6	Child								

II. Medical Conditions & Treatments

Has any person listed above seen a medical provider, had treatment recommended, received care (including prescriptions) or been hospitalized for any of the following?

***** Check "YES" or "NO" for each question. Please complete ADDITIONAL DETAIL TABLE on p. 2 for ALL "Yes" answers.**

<p>1. Cancer (if yes, list location and type of cancer below) Yes No</p> <p>Location and type of cancer _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>Check one: ___Stage 1, ___Stage 2, ___Stage 3, ___higher</p> <p>Date of remission (if applicable): _____</p>	<p>6. Arthritis (i.e. rheumatoid, osteo, psoriatic, gout) Yes No</p> <p><input type="checkbox"/> <input type="checkbox"/></p>
<p>2. Cardiac or Heart Disease / Disorder Yes No</p> <p>If yes, check all that apply: <input type="checkbox"/> <input type="checkbox"/></p> <p>___ heart attack,</p> <p>___ bypass surgery or angioplasty on single vessel, or</p> <p>___ bypass surgery or angioplasty on multiple vessels;</p> <p>___ ANY other heart conditions (list here): _____</p> <p>(i.e. arrhythmia, aneurysm, heart failure, heart valve disorder)</p>	<p>7. Autoimmune Disease (i.e. lupus, MS, anemia) <input type="checkbox"/> <input type="checkbox"/></p> <p>8. Back Disorder (i.e. degenerative disk disease, herniated disk, spinal fusion, spondylitis, strain) <input type="checkbox"/> <input type="checkbox"/></p>
<p>3. Diabetes (if yes, list type 1 or 2) Yes No</p> <p>Type: _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>If yes, list 3 most recent HbA1c / fasting blood sugar levels:</p> <p>1) 2) 3)</p>	<p>9. Benign Growth (i.e. tumor, cyst) <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Bowel (i.e. irritable bowel IBS, Crohn's ileitis) <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Circulatory System Disease (i.e. stroke, arterial / vascular diseases) <input type="checkbox"/> <input type="checkbox"/></p>
<p>4. High Cholesterol Yes No</p> <p>If yes, list 3 most recent readings:</p> <p>1) 2) 3)</p>	<p>12. Immunodeficiency (i.e. AIDS, HIV+, hemophilia) <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Kidney Disorder (i.e. nephritis, renal failure) <input type="checkbox"/> <input type="checkbox"/></p> <p>14. Liver Disease (i.e. cirrhosis, hepatitis A, B, C, E) <input type="checkbox"/> <input type="checkbox"/></p>
<p>5. High Blood Pressure Yes No</p> <p>If yes, list 3 most recent readings:</p> <p>1) 2) 3)</p>	<p>15. Mental Illness (i.e. mild or major depression, anxiety, bipolar disorder, or schizophrenia) <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Counseling Current or prior counseling? <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Muscular Disorder <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Respiratory (i.e. asthma, allergies, pneumonia, COPD, emphysema, bronchitis) <input type="checkbox"/> <input type="checkbox"/></p>
	<p>19. Stomach (i.e. ulcer, acid reflux, GERD) <input type="checkbox"/> <input type="checkbox"/></p> <p>20. Substance dependency (i.e. alcohol, drug) <input type="checkbox"/> <input type="checkbox"/></p> <p>21. Transplants (if yes, list organ(s): _____) <input type="checkbox"/> <input type="checkbox"/></p>

II. Medical Conditions & Treatments (continued) Yes No

- 22. Is anyone currently taking **prescription medication(s)**?.....
- 23. Has anyone had any of the following for a **serious illness** in the past 5 years?
 - a) treatment.....
 - b) hospitalization.....
 - c) surgery.....
- 24. Is anyone **currently**:
 - a) hospitalized or confined in a treatment facility?.....
 - b) confined at home, incapacitated or incapable of self-support?.....
- 25. Is any of the following **pending**?
 - a) treatment (medical treatment or diagnostic testing).....
 - b) hospitalization.....
 - c) surgery.....
- 26. In the past 5 years, has anyone enrolling had **symptoms** of any serious medical condition not yet indicated on this form?.....

Reminder:
Please complete
**ADDITIONAL DETAIL
TABLE**
for **ALL** items answered
"YES"
on Pages 1 & 2

III. Pregnancy and Childbirth Yes No

- 27. Is anyone **pregnant?** (If no, mark "No" and skip question 27.).....
- a) The due date is: _____
- b) Is this a High Risk Pregnancy, any complications or bleeding?.....
- c) Previous c-section or pre-term birth?.....
- d) Are multiple births expected? If so, please check one: twins triplets more

ADDITIONAL DETAIL TABLE - Please Fill In Details Below For All Questions Answered "YES"

Question #	Name of Individual	Condition / Diagnosis	Date of Onset	Last Date Treated	Treatment / Drug	Still taking? (Y/N)	Degree of Recovery

*** If you marked "Yes" to any item on Page 1 or 2, please complete ADDITIONAL DETAIL TABLE above, or this form will not be accepted.**

This information is gathered so that Kymberly Group, its actuaries, and its insurers can perform actuarial and other analyses of your group, which is considering participating in certain Kymberly Group group benefit plans. By signing this form you consent to such use, and your consent will remain effective unless and until revoked. Signing this form does not enroll you in an Kymberly Group benefit plan, nor is it a condition of treatment, payment, enrollment, or eligibility under Kymberly Group benefit plans. Kymberly Group's Notice of Privacy Practices provides more detailed information about how your protected health information may be used by Kymberly Group under privacy laws, and you consent to such uses. You have the right to review the Notice of Privacy Practices before signing this form. Kymberly Group will treat your information in accordance with this consent and the Notice of Privacy Practices, but once your information has been disclosed to others it may no longer be protected by privacy laws. You may revoke your consent at any time; revocation will be effective as of the date received in writing by the Kymberly Group benefits department and will not apply to information that has already been used or disclosed in reliance on your previous consent. Kymberly Group will provide you a copy of this form as signed by you on your written request.

By signing below you certify that: you have given your consent voluntarily; you understand that Kymberly Group and its insurers and actuaries will rely on the information you provide; and the information you provide on this form is true and complete to the best of your knowledge (however, persons employed in Michigan should omit information about height and weight). You also agree to immediately notify Kymberly Group in writing of any changes to the information you provide on this form that you become aware of between your submission of this form and the date upon which you become covered by any Kymberly Group benefit plan. If you knowingly make any misrepresentations or omissions on this form, or in updating or failing to update the information on this form, it could result in denial of claims, changes in coverage terms and premium, and/or cancellation or rescission of all coverage under Kymberly Group benefit plans.

Employee SIGN HERE and Date:

➔ _____ Date: _____