Sentara Health Plans

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FOR PLAN USE ONLY
Subscriber #:
Date:

1300 Sentara Park
Virginia Beach, VA 23464

☐ **Sentara Health Plans** ☐ **Sentara Health Insurance Company**

Employee Health Questionnaire

IMPORTANT:
ONLY complete this form if your employer has 51 or more total employees AND less than 151 of those employees are eligible for the health plan.

INFORMATION **(PLEASE PRINT LEGAL NAME)**

Please provide the name and date of birth of each person listed on your completed member application:

Employee	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)
Spouse	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)
Domestic Partner	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)
Child 1	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)
Child 2	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)
Child 3	Last Name	First Name	Middle Initial	Date of Birth (mm/dd/yyyy)

Sentara Plan Selection

	HMO/POS Products Underwritten by Sentara Health Plans		*PPO Products Underwritten by Sentara Health Insurance Company*
Please Check One:	☐ Vantage *(HMO)*	☐ POS/ POSA (POS)	☐ Plus *(PPO)*
Enter Plan Name:	_____		

Group Number	Group Name	***Employee Health Questionnaire***
Effective Date	Subscriber Membership Number	Subscriber Name

A. HEALTH QUESTIONS

(TO BE COMPLETED BY EMPLOYEE FOR EMPLOYEE AND ALL DEPENDENTS TO BE COVERED)

SECTION 1: Within the past 5 years, have you, or any person on your completed application, had or been treated for the following diseases or impairments? Please check the appropriate box beside the condition and provide details in SECTION B for any condition checked "yes":

Yes No	Yes No	Yes No
☐ ☐ Liver Disorder (Hepatitis/Cirrhosis)	☐ ☐ Diabetes	☐ ☐ Gall Bladder Trouble
☐ ☐ Kidney/Bladder Problems	☐ ☐ Stomach Ulcers	☐ ☐ Tumors
☐ ☐ Stomach/Intestinal Disorder	☐ ☐ Arthritis	☐ ☐ HIV
☐ ☐ Disease/Disorder of Spine or Back	☐ ☐ Alcohol or Drug Abuse	☐ ☐ Tuberculosis
☐ ☐ Cancer	☐ ☐ Epilepsy	☐ ☐ Brain Disorder
☐ ☐ Sexually Transmitted Disease	☐ ☐ Current Pregnancy (Due Date _____/_____/_____)	☐ ☐ Connective Tissue Disease (Lupus)
☐ ☐ Asthma (Date of last attack _____/_____/_____)	☐ ☐ Acquired Immune Deficiency Syndrome (AIDS)	☐ ☐ Allergies
☐ ☐ Nervous/Mental or Psychological Disorder	☐ ☐ Hemophilia	☐ ☐ Sleep Apnea
☐ ☐ Multiple Sclerosis	☐ ☐ Gout	☐ ☐ Cerebral Palsy
☐ ☐ High Cholesterol	☐ ☐ Heart Problems	☐ ☐ Cystic Fibrosis
☐ ☐ High Blood Pressure	☐ ☐ Thyroid Trouble	☐ ☐ Emphysema
		☐ ☐ Respiratory Disorders
		☐ ☐ Circulatory Problems

Additional Information About You and Your Dependents:

	Height	Weight		Height	Weight
Employee:	ft. in.	lbs.	**Spouse:**	ft. in.	lbs.
Domestic Partner:	ft. in.	lbs.	**Child 1:**	ft. in.	lbs.
Child 2:	ft. in.	lbs.	**Child 3:**	ft. in.	lbs.

1. Within the past five (5) years, have you, or any person named on your completed application, consulted a physician or other provider for medical or surgical treatmentor advice for any condition NOT listed in SECTION 1? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS B (a) and B (b).
2. Within the past five (5) years, have you, or any person named on your completed application, been advised to have an operation which has not been performed or to enter a treatment program not currently being received? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS B (a) and B (b).
3. Within the past five (5) years, have you, or any person named on your completed application, been declined on a previous health insurance application? ☐ Yes ☐ *No*
   (If Yes,please provide details in SECTIONS B (a) and B (b).

Group Number	Group Name	***Employee Health Questionnaire***
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B.(a) PRESCRIPTION MEDICATION HISTORY

Please provide information on any prescribed medication (including injections) that you or any of your listed dependents have used within the past 5 years. Please provide information on past and current prescription drug usage. If you need more space, please reprint this page to add additional information.

Individual's First Name	Medication	Dosage (amount and frequency)	Beginning date of use	Ending date of use

B. (b) MEDICAL TREATMENT HISTORY

If you checked "Yes" to any part of SECTION 1, please provide complete information regarding diagnosis, condition, or treatment – include all hospitalizations, surgery, and diagnostic testing. If you need more space, please reprint this page to add additional information.

Individual's First Name	Diagnosis/Condition/Treatment	Date Diagnosed	Attending Physician's Name and Address	Complete Recovery?

Group Number	Group Name	*Employee Health Questionnaire*
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C. MEDICAL PROFILE SUPPLEMENT CERTIFICATION

Please read and provide signature and date. Signature is REQUIRED for underwriting review.

I have read or had read to me the completed application and realize that if I make any false statements or an intentional material misrepresentation of fact in this application it may result in loss of coverage or no coverage. I acknowledge that if my coverage is terminated or rescinded because of my misrepresentations or fraudulent actions, I would be responsible for paying health care claims I incurred and not Sentara Health Plans or Sentara Health Insurance Company.

I understand and agree that Sentara Health Plans or Sentara Health Insurance Company, as checked on page 1 of this application, will rely upon the above information and answers as the basis for establishing group premium rates for health care coverage.

I authorize any physician, hospital, clinic, other medical or medically-related provider, facility, insurance company or other organization, institution or person that has any knowledge of my health or the health of my spouse, Domestic Partner, and/or dependents as listed on my completed member application to disclose such information to the extent permitted by law to Sentara. The information disclosed to Sentara will be used for the purpose of compiling an accurate evaluation of this application and to establish group premium rates for the group.

I understand this authorization shall extend to representatives of Sentara, as checked on page 1 of my completed member application, as needed to fulfill the purposes of the disclosure. This authorization does not permit the use or disclosure of psychotherapy notes. This authorization is valid for the term of coverage under the group plan in connection with claims payment, and in connection with an application for coverage, policy reinstatement or a request for change in policy benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand that I may be contacted by Sentara, as checked on page 1 of my completed member application, to obtain additional follow-up information on health conditions disclosed in Section B of this questionnaire for me, my spouse, Domestic Partner, and/or my covered dependents.

I understand that I or my authorized representative may receive a copy of this authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

I certify that I am working at the employer's place of business in full-time employment at least twenty-five (25) hours per week.

I understand that coverage will be through my employer's health plan. I understand that my employer's application will determine the coverage and that coverage will only be in place if an application for the coverage has been made by my employer. I authorize my employer to make deductions from my earnings necessary to provide my contribution for this coverage and I understand that my employer is performing this service for my benefit and is not an insurance agent for Sentara.

I am applying for health coverage for the persons listed and agree that we shall abide by the provisions of coverage in the coverage document under which we will be enrolled. I understand that I am obligated to select a Plan-participating primary care physician for myself and for my covered dependents if choosing Sentara Health Plans HMO or Sentara Health Plans POS/POSA. I understand that it is my responsibility to report to the plan indicated on page 1 of this application any change in eligibility of my dependents. If requested, documentation will be supplied. I also understand that I am obligated to pay applicable Copayment or Coinsurance at the time services are rendered.

Employee Name (*Please Print*)	Company name:	
Employee Signature in ink	**Date:**	Daytime Phone:

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