UISWA/CEA Health Questionnaire
For Groups of 5 or less

Employer's Name _____

Applicant's Name _____

Applicant's Height _____ **Weight** _____ **Sex (Male / Female)** _____

Health History for Applicant and ALL Dependents *(Include information for all persons applying for coverage.)*

1. Within the last 5 years have you been treated for, or has a doctor advised you that you have, any of the following conditions (please check all that apply):

A ☐ Heart or valve condition - Stroke
B ☐ Kidney/Bladder condition
C ☐ Cancer (describe type of Cancer) _____
D ☐ Are you an expectant parent?

	Yes	No
2. Are you or any person to be insured currently taking any prescription medication, over-the-counter medication, vitamin therapy or alternative remedies (including herbs)?	☐	☐
3. Within the last 3 years have you been advised to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?	☐	☐
4. Have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, life insurance, or long term care with another insurance carrier?	☐	☐
5. Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex by a physician or member of the medical profession, or had a T-cell abnormality?	☐	☐

Answer all questions above & provide complete details to all "Yes" answers

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that the Health Statement is part of my request for health coverage and that if I have misrepresented or omitted any material fact, my coverage may be cancelled or the contract rescinded.

Applicant Signature: _____ **Date:** _____