

**FIRSTCAROLINACARE INSURANCE COMPANY
EMPLOYEE HEALTH QUESTIONNAIRE**

The confidential information provided on this form will be used to determine appropriate premium rates for the applicable employer group. You cannot be declined for coverage based on the information provided on this form, and you will not be individually charged a higher premium based on your responses. *No information on this form will be disclosed to your employer. Separate forms must be completed by the employee **and** by the spouse if enrolling in FirstCarolinaCare Insurance Company.*

Employer Name: _____

Employee OR Covered Spouse Name: _____

1. Please provide the following information for the person named above:

Sex: Male Female Date of Birth: ___/___/___

Height: _____ Weight: _____

Do you use tobacco products? Yes No

2. Have you been diagnosed with or currently being treated for any of the following conditions? Please check Yes or No and list any treatments received and approximate dates.

Condition		Treatment/Dates	Condition		Treatment/Dates
Back or spinal disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		Multiple sclerosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Paralysis	<input type="checkbox"/> Yes <input type="checkbox"/> No		Stomach/ bowel disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No		Crohn's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cerebral palsy	<input type="checkbox"/> Yes <input type="checkbox"/> No		High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Parkinson's disease	<input type="checkbox"/> Yes <input type="checkbox"/> No		Diabetes mellitus	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other neurological disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		Heart attack	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Liver disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No		Congestive heart failure	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No		Other heart condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other lung disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No		AIDS/HIV*	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No		Eating disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Tumors/ growths	<input type="checkbox"/> Yes <input type="checkbox"/> No		Mental/emotional disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No		Rheumatoid arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	

* "AIDS" means Acquired Immune Deficiency Syndrome. "HIV" means Human Immunodeficiency Virus.

3. If anyone listed above takes prescription medications (including fertility drugs), please explain below:

Name	Drug and dosage	For what condition prescribed

4. If you are female, are you now pregnant? Yes No

If yes, due date: _____

Is the pregnancy high risk or expected to have complications? Yes No If yes, please explain: _____

5. Has any surgery, hospitalization, diagnostic testing or other medical treatment been received in the last 2 years or recommended for you? Yes No If yes, please explain: _____

6. Have you been turned down for health coverage by any insurer or health plan?

Yes No If yes, please explain: _____

7. Are you under 65 and covered by Medicare? Yes No

If yes, please explain: _____

ACKNOWLEDGEMENT

The information provided on this form is protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). FirstCarolinaCare Insurance Company (FCC) will safeguard my PHI and will not disclose it unless I request it or where the disclosure is permitted or required by state or federal law. The PHI provided on this form will be used to determine premium rates for the applicable employer group. I understand that I cannot be declined for coverage based on the information I provide on this form. I understand that by signing this form I attest that all the answers are accurate and complete. I further understand that coverage will be issued in reliance upon the information herein. Any untrue or incomplete information, whether intentional or not, may result in a premium adjustment.

Employee/ Covered Spouse Signature

Date