

Health First Health Plans

Individual Health Status Questionnaire



6450 US Highway 1, Rockledge, Florida 32955
 Phone (321) 434-5665 Toll-free (800) 716-7737
 hfhpinfo@health-first.org

Employer name _____

healthfirsthealthplans.org

Please complete all questions for yourself (and your dependents, if dependent coverage is being requested).

Name	Relationship	SS#	Sex	Date of birth	Height	Weight
Employee						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						

- Do you or any dependent have an impairment in your physical condition? Y N
- Have you or any dependent been refused life insurance, any form of health insurance, or ever had a policy rated or modified? Y N
- Have you or any dependent during the last 2 years consulted with, been treated or examined by any physician or other practitioner? Y N
- Have you or any dependent during the last 2 years undergone a surgical procedure? Y N
- Have you or any dependent during the last 2 years been confined or treated in any hospital? Y N
- Have you or any dependent EVER been treated for or had any indication of heart trouble, high blood pressure, sugar in urine, diabetes, cancer, tuberculosis, tumor, ulcer, emphysema, alcoholism, drug abuse, mental or nervous disorder? (If YES, indicate the disorder by underlining.) Y N
- Have you or any dependent tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? Y N
- Are you or any dependent now receiving or contemplating medical attention, surgical treatment or taking medication? Y N
- Are you or any dependent now pregnant? (If YES, due date: _____) Y N

Give complete details regarding any of the above question(s) to which you answered "Yes":

Question number	Person treated	Medical condition, type of treatment (including any medication)	Duration dates		Degree of recovery (%)	Name and address of physician, hospital or clinic
			From (mo/yr)	To (mo/yr)		

I HEREBY AUTHORIZE Health First Health Plans to use the individually identifiable health information on this Health Status Questionnaire for underwriting/rating purposes. I understand that this authorization is voluntary and that I may refuse to sign this authorization, however my enrollment in Health First Health Plans may be conditioned on its provision. I UNDERSTAND that this authorization will be in effect during the underwriting process, throughout any subsequent enrollment in Health First Health Plans, and 7 years after my membership with Health First Health Plans ends. I UNDERSTAND that my dependents, or I may be required to provide additional information regarding any of the above responses, including providing a medical release to obtain medical records. I have read, or have had read to me, all information contained in this form and such information is accurate and complete to the best of my knowledge. I UNDERSTAND that if I have made any material false statement, misrepresentation or omission on this form which changes the risk assumed by this plan, I may lose coverage under Health First Health Plans, Inc. Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree (under Florida Law Chapter 95-340).

Signature	Date
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