APPENDIX VV. UNIFORM HEALTH QUESTIONNAIRE

UNIVERSAL HEALTH QUESTIONNAIRE **OKLAHOMA**

Individual Health Statement	**Employer Plan Name:** **EMPLOYEE NAME:**

Enrollment, please check one. If waiving coverage, please see next box	Waiving Medical (please check box)	City, State, County and Zip Code of Residential Address:
☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Employee/Family	☐	

1. **Only Individual(s) Requesting Coverage at this Time Should be Listed.** Check here if additional dependent children are listed on a separate attachment. (Be sure to include their sex, birthdate, height and weight.)

		Birthdate	Height (ft., in.)	Weight (lbs.)
Employee	☐ M ☐ F Social Security Number _____ Tobacco Use ☐ Y ☐ N			
Spouse	☐ M ☐ F			
Dependent Child	☐ M ☐ F			
Dependent Child	☐ M ☐ F			
Dependent Child	☐ M ☐ F			

2. Answer all questions: Within the last five years has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.)

a. ☐ AIDs or HIV
b. ☐ Diabetes
c. ☐ Infertility
d. ☐ Endocrine/Metabolic
e. ☐ Pancreas
f. ☐ Liver/Hepatitis
g. ☐ Immune System
h. ☐ Blood Disorder
i. ☐ Epilepsy/Seizure
j. ☐ Heart
k. ☐ Paralysis/Paresis
l. ☐ Tumor/Cyst/Growth
m. ☐ Systemic or Discoid Lupus
n. ☐ Lung or Respiratory
o. ☐ Alcohol or Drug Use
p. ☐ Kidney/Bladder/Urinary
q. ☐ Circulatory/Vascular
r. ☐ Digestive/Stomach/Intestinal
s. ☐ Central Nervous System
t. ☐ Pituitary/Adrenal/Growth Disorder
u. ☐ Birth Defects/Congenital Abnormalities
v. ☐ Arthritis/Bone/Joint/Muscle/ Prosthetic Device
w. ☐ Mental/Nervous/Emotional/Eating Disorder
x. ☐ Stroke/Brain/Neurological
y. ☐ Transplant ☐ Recommended ☐ Pending ☐ Complete
z. ☐ Advised to have surgery or course of treatment not yet determined
aa. ☐ Cancer: Type: _____Stage: _____ ☐ Surgery ☐ Chemo ☐ Radiation
bb. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair
cc. ☐ Other_____

3. Is any female currently pregnant? If so, provide due date _____ Check applicable boxes: ☐ C Section Planned ☐ Multiple Births Expected (# ____) ☐ Complications: ☐ Past or ☐ Present	☐ Yes ☐ No
4. Has anyone applying for coverage incurred medical expenses in excess of $5,000 in the past 24 months?	☐ Yes ☐ No
5. Has anyone applying for coverage been prescribed medications in the past 12 months?	☐ Yes ☐ No
6. Does anyone applying for coverage have a known condition that requires on-going treatment?	☐ Yes ☐ No

Question Number	Name of Individual	Condition/Diagnosis	Date of Onset	Date Treatment Ended	Names of Prescription Medication	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

Certification and Authorization: I acknowledge that I have read all sections of this Uniform Health Questionnaire (Questionnaire) and I certify on behalf of my eligible family dependents and myself that the answers contained in the Application are complete and accurate to the best of my knowledge. I understand and agree that neither my employer nor any insurance producers have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any carrier's other rights or requirements. I understand and agree that any information obtained in connection with this Questionnaire will be used by small employer carrier(s) to determine eligibility for coverage, underwriting and for any other purposes related to providing coverage. On behalf of my eligible family dependents and myself, I authorize any provider of health services or supplies, insurance company, health care clearinghouse, pharmacy benefit manager, and any other person with knowledge or records to release information to any small employer carrier, its agents and legal representatives, about any and all health-related services and supplies provided or to be provided to me or my eligible family dependents. I understand that I may request a copy of this Questionnaire. I agree that a photographic copy of this Application shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

LAST 4 DIGITS OF SSN:	**DATE:**

You are NOT required to share this information with your employer. You may, at your discretion, return this completed questionnaire in a sealed envelope. Please write your name on the outside of the envelope for easy identification.

[Added at 29 OK Reg 1283, eff 7-14-12]