

Rhode Island Health Screening Questionnaire

Company Name: _____

Employee Name: _____

Employee Address: _____

Street Address

City/Town

State

Zip

- Read Carefully Before Signing -

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us") I authorize any health care professional or entity to give United HealthCare of New England, Inc. and United HealthCare Insurance Company any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for purpose of identification. I understand and agree that any omissions or incorrect statement made on this application may invalidate my and/or my dependents' coverage. I understand that this will become effective only on the date specified by the Insurer after it has been approved by the Insurer and after the full premium has been paid. By signing this form, I hereby certify that all the information provided is true and correct.

I understand that if I and/or my dependents, if any, waive coverage and desire to participate in the plan at a later date, coverage may be subject to treatment as a late enrollee. I further understand that if I decline enrollment for myself or my dependents (including my spouse) because of other health coverage, I may in the future be able to enroll myself or my dependents in this plan, provided I request enrollment within 30 days after such coverage ends. In addition, if a new dependent relationship forms as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after such marriage, birth, adoption, or placement for adoption.

Employee Signature

Date

Instructions:

1. Complete all information requested.
2. To keep health information confidential, moisten gummed edge of document, fold at score and seal.
3. Staple or tape the Enrollment/Change Form to this form.
4. Return to your employer.

CONFIDENTIAL

Rhode Island Small Group - Health Information -

Applicant Marital Status: Single Married Number of Dependents _____

Applicant Social Security Number: # _____

	First Name	MI	Last Name	Male	Female	Date of Birth
Applicant:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /
Spouse:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /
Dependent:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /
Dependent:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /
Dependent:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /
Dependent:	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	/ /

Health Information - Explain any "YES" answers in complete detail. Use extra paper if necessary.

1. Have you or your dependents had or been treated during the past ten years for:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| A. diabetes or sugar, albumin or blood in the urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. high blood pressure, chest pain, heart murmur, shortness of breath, angina or other heart or circulatory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. stroke, epilepsy, fainting, dizziness, headaches or any disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. stomach or duodenal ulcer, other ulcer, colitis, disorder of the gall bladder, liver, stomach or intestines? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. kidney, bladder or prostate disorder or other urinary disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| F. tumor or disease or dysfunction of the breast, reproductive organs or abnormal menstrual period? | <input type="checkbox"/> | <input type="checkbox"/> |
| G. arthritis, rheumatism or any pain/disorder of the joints, muscles, back or bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| H. cancer or tumor or ulcer of any kind, growth or cyst? | <input type="checkbox"/> | <input type="checkbox"/> |
| I. nervous, mental, sleep disorder, alcoholism or drug habit (including professional counseling)? | <input type="checkbox"/> | <input type="checkbox"/> |
| J. disease of the immune system including AIDS or ARC? | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, please list name, date, diagnosis and degree of recovery: _____

2. Within the past 5 years, have you or your dependents:
- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| A. had a routine physical exam? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. had an electrocardiogram, X-ray, blood test or diagnostic test, or seen a physician for any medical reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. had inpatient or outpatient surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. been advised to have surgery not yet done? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. had any medical treatment, mental or physical impairment, condition or congenital anomaly not mentioned above? | <input type="checkbox"/> | <input type="checkbox"/> |
- If yes, please list name, date, diagnosis and degree of recovery: _____

3. Have medications been prescribed for you or your dependents in the last 12 months for any reason? Yes No
- If yes, please list name, dose, and condition used for: _____

4. Are any family members pregnant (including spouse not applying for coverage)? Yes No
- If yes, when is delivery expected? _____