



Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Attn: Membership #4
P.O. Box 30270
Salt Lake City, Utah
84130-0270

GROUP HEALTH QUESTIONNAIRE

MUST BE COMPLETED BY THE EMPLOYEE ON BEHALF OF ALL FAMILY MEMBERS INCLUDING ALL WHO ARE WAIVING COVERAGE
AN INCOMPLETE QUESTIONNAIRE WILL BE RETURNED

Name of Employer's Group _____

Table with 5 columns: Name, Date of Birth, Height, Weight, Social Security Number. Rows for Employee, Spouse, and three Dependent Children.

Note: Attach information on additional children

Complete the following information for all family members (whether or not they are applying for coverage). Consult with them to ensure that the information you provide is true, accurate and complete. You cannot be denied coverage on the basis of any health history that you provide which is true, accurate and complete to the best of your knowledge.

Form with 7 numbered questions regarding health history, family members' health, and current medical conditions. Includes Yes/No checkboxes.

8. FOR EACH QUESTION 1 THROUGH 7 ABOVE ANSWERED "YES," PLEASE COMPLETE THE FOLLOWING: (more space provided on back)

Table with 6 columns: Item # & Letter, Patient's First Name, List condition, disorder, disease, problem, treatment, medication and degree of recovery, Was Patient Hospitalized?, Dates of Care, Actual or Expected Cost of Care.

I certify that I have consulted all family members (whether applying for or waiving coverage) about their health history and that the above information is true, accurate and complete to the best of my knowledge. I acknowledge that any coverage issued by Regence BlueCross BlueShield of Utah, Regence ValueCare and/or Regence HealthWise (hereinafter referred to as "the Plan") will be issued in reliance upon the truth, accuracy and completeness of this information, but understand that coverage cannot be denied on the basis of any health history that I provide which is, to the best of my knowledge, true, accurate and complete.

I hereby authorize any health-care professional or other person or entity to release to the Plan any record, document or other information in connection with any inquiry or investigation into the truth, accuracy or completeness of the information I have provided herein. I further agree to execute releases requested by the Plan for medical and other records and agree that the Plan may cancel my coverage retroactive to its original effective date if I refuse to provide such a release within thirty (30) days after request by the Plan.

I understand and agree that this and all other documents submitted by me remain the exclusive property of the Plan. Any matter in dispute between myself and the Plan may be subject to arbitration as an alternative to court action pursuant to the rules of the American Arbitration Association or other recognized arbitrator, a copy of which is available on request from the Plan.

I have the option of returning this form to my employer, or I may mail it directly to Regence BlueCross BlueShield of Utah, Membership Department, P.O. Box 30270, Salt Lake City, UT 84130-0270.

