

MD Health Group, PPC
Employee Questionnaire

EMPLOYER INFORMATION

Employer Name _____ Occupation _____

Names of Insurers to whom information may be released: Insurer: BCBS of Texas, Dearborn National

I. EMPLOYEE INFORMATION

Employee Instructions: Please print using black or blue ink. Please fill out the entire form for each person for whom coverage is being sought.

Employee's First Name _____ Middle Initial _____ Last Name: _____

Street or Post Office Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Date of Birth: _____

1. For your current employer: What was your first day of employment? ____/____/____

2. Are You: a) Single Married Legally Separated Divorced Widow or Widower

3) On COBRA or State Continuation? Yes No

If "Yes," provide start date and reason: _____

II. TYPE OF HEALTH COVERAGE

Please select the type of health insurance coverage for which you are applying:

Employee Only Employee and Spouse Employee and Dependent Child(ren) Employee, Spouse and Dependent Child(ren)

Waive all coverage (Please provide date of birth below)

III. EMPLOYEE AND DEPENDENT INFORMATION

a) List employee and all dependents, spouse and child(ren) applying for insurance. If you need additional space, please use a separate sheet of paper and attach it to this form (**please sign and date the additional sheet**). An eligible "dependant" is an employee's lawful spouse; unmarried children or step-children who are under age 26; adopted children under age 26; or grandchildren who are under age 26 and are dependants for federal income tax purposes.

Relationship	Sex	Last Name	First	M.I	Birth Date (Mo/Day/Yr)	Height	Weight
Employee							
Spouse							

b) Is anyone named on this form now disabled, mentally incompetent or unable to perform normal work or age-related activities?

Yes No

If "Yes," please identify name(s), health condition(s), date(s) of disability: _____

V. AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization form carefully before signing. This form must be signed by each adult person seeking coverage, including all adult dependent children. Signature below by Employee and Spouse (if applicable) shall also serve to sign for their minor children, unless the minor has received treatment without parental consent, consistent with state law. In that instance, the minor child must also sign

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my, my spouse's and my dependent child(ren)'s protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I, my spouse or my dependent child(ren) have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I, my spouse and my dependent child(ren) authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage for me, my spouse and my dependent child(ren), to determine eligibility for enrollment or benefits under a health plan ("Purpose").

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM. I ACKNOWLEDGE THIS IS NOT AN APPLICATION FOR COVERAGE, NOT A CONTRACT, NOT A GUARENTEE OF COVERAGE AND IS USED TO UNDERWRITE THE GROUP FOR MEDICAL COVERAGE. I UNDERSTAND I SHOULD NOT CANCEL ANY CURRENT COVERAGE UNTIL I HAVE RECEIVED WRITTEN CONFIRMATION OF NEW COVERAGE FROM MD HEALTH GROUP, PPC.

Signature of Employee	Date signed	Printed Name
Signature of Spouse (if applicable)	Date signed	Printed Name
Signature of Adult Child (if applicable)	Date signed	Printed Name
Signature of Adult Child (if applicable)	Date signed	Printed Name
Signature of Minor Child (if applicable)	Date signed	Printed Name

Additional Information: