



Health Net®

Health Questionnaire

To be completed by employee

Check one

Initial enrollee Late enrollee(s) Existing member

Please provide complete information to assure timely administration of claims. Information provided will not cause medical plan enrollment denial. (If you and your eligible dependents have chosen to waive health coverage, you are not required to complete this questionnaire.)

Part I. Health plan information			
Employee name:	Gender:	Height:	Weight:
Social Security number:	DOB:	Employer name:	

Part II. Health questionnaire		
Please answer Yes or No to each of the following questions for yourself and each of your dependents. For each "Yes" answer, please explain and provide complete details. Genetic Information Nondiscrimination Act of 2008 (GINA) Compliance Statement: This is not a request for genetic information. In answering this Health Questionnaire, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling or genetic diseases for which you believe you may be at risk.		
Have you or any of your dependents been diagnosed with, treated for, or had treatment recommended by a medical professional within the last five (5) years for any of the following:		
1)	Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2)	Hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3)	Cancer, tumor or other malignancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4)	Diseases of the kidney, liver, gall bladder, pancreas or male/female organs or sexually transmitted disease except HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5)	Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6)	i. Immune deficiency disorders, infections or chronic infection problems not related to AIDS or AIDS-Related Complex?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	ii. Have you or any applying family member been diagnosed as having or been treated for AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7)	Alcohol or substance abuse, mental/nervous disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8)	Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9)	Diabetes, cystic fibrosis, albumin or sugar in the urine or other endocrine problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10)	Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11)	Paralysis, epilepsy, MS or other neuromuscular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
12)	Bleeding or blood disorders except HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No

(continued)

Part II. Health questionnaire (continued)

Other conditions/information:

13)	Are you or any dependents now pregnant? If "Yes," is this your first pregnancy? Complications with this or any prior pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
14)	Any other medical condition in the last five (5) years that has not been disclosed? If so, describe in detail below. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
15)	Have you or your dependents smoked in the last two (2) years? If "Yes," date stopped: _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
16)	Are you or any of your dependents taking any medication (except antibiotics or contraceptives) that require a prescription by a physician?	<input type="checkbox"/> Yes <input type="checkbox"/> No
17)	Have you or your dependents gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
18)	Are you actively at work at least 20 hours per week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
19)	Have you or your dependents been admitted to a hospital or had surgery in the past five (5) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
20)	Have you or your dependents been told that it may be necessary to be admitted to the hospital or have surgery in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part III. Detailed explanations

Item #	Name of person treated	Height / weight	Diagnosis condition	Type of treatment	Medications / dosage	Treatment provider	<input type="checkbox"/> Still under treatment – treatment dates
		Height:				Physician name:	Date treatment began:
		Weight:				Hospital/facility name:	Date ended (if applicable):
		Height:				Physician name:	Date treatment began:
		Weight:				Hospital/facility name:	Date ended (if applicable):
		Height:				Physician name:	Date treatment began:
		Weight:				Hospital/facility name:	Date ended (if applicable):

Part IV. Signature

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Health Statement is part of my request for health coverage. Information provided will not cause medical plan enrollment denial.

Employee signature: _____ Date: _____