

# Individual Medical Questionnaire Form

(For groups with 5-8 enrolled employees)



An Independent Licensee of the Blue Cross Blue Shield Association

Employer Name \_\_\_\_\_

Employee Name \_\_\_\_\_  
 Last First Middle

M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Employee Marital Status  Single  Married

Spouse Name \_\_\_\_\_  
 Last First Middle

M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Child Name \_\_\_\_\_  
 Last First Middle

M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Child Name \_\_\_\_\_  
 Last First Middle

M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Child Name \_\_\_\_\_  
 Last First Middle

M  F Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Have you or any member of your family **enrolling for coverage been diagnosed, by a physician**, received treatment or are currently receiving treatment for any of the following conditions within the past **10 years** (please complete each question):

- |   |  |   |  |
|---|--|---|--|
| 1. Cancer or tumor?                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Neurological conditions?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Diabetes?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have any claims over \$5,000 been billed in the last 18 months?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Alcohol/illicit drug use or abuse?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Are there any ongoing disabilities?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Liver disease/Cirrhosis/Hepatitis?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Are you or your spouse/dependent currently pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Lung or respiratory conditions?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Are you or your spouse/dependent currently taking any medications?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Gall bladder, liver, stomach or intestines?        | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have you, your spouse, or any dependent children been a patient in a hospital, clinic, surgi-center, sanatorium, urgent care facility, or other medical facility as an inpatient or outpatient? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Immune System?                                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 8. Psychological conditions?                          | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 9. Heart conditions/hypertension/stroke?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10. Bones/Joints/Muscles/Arthritis?                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 11. Kidney/Urinary tract/bladder (stones, infection)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |

**Explanation Section** Explain any "Yes" below (attach additional sheets if necessary)

Question #	Name/Age	Diagnosis Date	Diagnosis, Date Diagnosed and/or Medications (Name of medication, dosage, frequency, reason for taking/diagnosis)	Last Date of Treatment

**Signature** (This form must be signed and dated.)

I represent that, to the best of my knowledge, the information provided on this form is complete and accurate. I understand that if I have misstated or omitted any information on this form, AZ Blue may reassess premium applied to my employer group and/or me, or terminate AZ Blue coverage in accordance with applicable law. AZ Blue, its reinsurers, and their authorized representatives may obtain medical information in order to evaluate the information contained in this form.

Employee Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

# Notice of Nondiscrimination



An Independent Licensee of the Blue Cross Blue Shield Association

## Discrimination Is Against the Law

**Blue Cross® Blue Shield® of Arizona (AZ Blue)** complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits, pregnancy or related conditions, sexual orientation, gender identity, and sex stereotypes). **AZ Blue** does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

### **AZ Blue:**

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 602-864-4884 for Spanish and 1-877-475-4799 for all other languages and other aids and services.

If you believe that **AZ Blue** has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

### **Section 1557 Coordinator**

**P.O. Box 13466**

**Phoenix, AZ 85002-3466; Call 602-864-2288, TTY: 711**

or email us at **[crc@azblue.com](mailto:crc@azblue.com)**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance,

**AZ Blue Section 1557 Coordinator** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at AZ Blue's website: [azblue.com/nondiscrimination-notice](http://azblue.com/nondiscrimination-notice).

## Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

**English:** Free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-877-475-4799.

**Spanish:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 602-864-4884.

**Navajo:** Diné bee yániit'i'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiiik'eh ná hóló. Bee ahít hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' dhoot'i'ígíí éí t'áá jiiik'eh hóló. Kohjí' 1-877-475-4799.

**Chinese Simplified:** 如果您说[中文], 我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务, 以无障碍格式提供信息。致电 1-877-475-4799。

**Chinese Traditional:** 如果您說[中文], 我們可以為您提供免費語言協助服務。也可以免費提供適當的輔助工具與服務, 以無障礙格式提供資訊。請致電 1-877-475-4799。

**Tagalog:** Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyong upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-877-475-4799.

**French:** Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-877-475-4799.

**Vietnamese:** Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-877-475-4799.

**German:** Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-877-475-4799.

**Korean:** 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-877-475-4799.

**Russian:** Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-877-475-4799.

### Arabic

تنبيه: إذا كنت تتحدث اللغة العربية، فستوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 1-877-475-4799.

**Hindi:** यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। 1-877-475-4799।

### Farsi (Persian)

همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. فارسی‌اگر توجه: 1-877-475-4799 با شماره دسترس، به‌طور رایگان موجود می‌باشند.

**Thai:** หมายเหตุ: หากคุณใช้ภาษาไทย เรามีบริการความช่วยเหลือด้านภาษาฟรี นอกจากนี้ยังมีเครื่องมือและบริการช่วยเหลือเพื่อให้ข้อมูลในรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่าย โปรดโทรติดต่อ 1-877-475-4799 หรือปรึกษาผู้ให้บริการของคุณ”

**Japanese:** 日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル(誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-877-475-4799。