Individual Risk Evaluation Form

Employer Name: _____

Employee Name: _____ ☐ ☐ Date of birth _____ Height _____ Weight _____
Last First M F

Employee Marital Status: ☐ Single ☐ Married

Spouse Name: _____ ☐ ☐ Date of birth _____ Height _____ Weight _____
Last First M F

Child Name: _____ ☐ ☐ Date of birth _____ Height _____ Weight _____
Last First M F

Child Name: _____ ☐ ☐ Date of birth _____ Height _____ Weight _____
Last First M F

Child Name: _____ ☐ ☐ Date of birth _____ Height _____ Weight _____
Last First M F

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

1. Cancer or tumor? ☐ Yes ☐ No
2. Diabetes? ☐ Yes ☐ No
3. Alcohol/illicit drug use or abuse? ☐ Yes ☐ No
4. Liver disease/cirrhosis/hepatitis? ☐ Yes ☐ No
5. Lung or respitorty conditions? ☐ Yes ☐ No
6. Gall bladder, liver, stomach or intestines? ☐ Yes ☐ No
7. Immune system? ☐ Yes ☐ No
8. Pshychological conditions? ☐ Yes ☐ No
9. Heart conditions/hypertension/stroke? ☐ Yes ☐ No
10. Kidney/urinary tract/bladder (stones, infection)? ☐ Yes ☐ No
11. Bones/joints/muscles/arthritis? ☐ Yes ☐ No
12. Neurological conditions? ☐ Yes ☐ No
13. Incurred any claims over $5000? ☐ Yes ☐ No
14. Any ongoing disabilites? ☐ Yes ☐ No
15. You or spouse currently pregnant? ☐ Yes ☐ No
16. Anyone currently taking medication? ☐ Yes ☐ 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 in inpatient or outpatient? ☐ Yes ☐ No

EXPLANATION SECTION **Explain any "Yes" below (attach additional sheet if necessary)**

Question #	Name/Age	Diagnosis Date	Diagnosis and/or medications (name of medication, dosage, frequency)	Last date of treatment	Doctor's Name/Phone

Signature (This form must be signed)

_____ _____
Employee Signature Date signed

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