Individual Underwriting Questionnaire

Name of Employer Providing Medical Coverage: _____
Name of Employee Benefit Plan: _____

Section I – Personal Information

Employee Name						
Last	First	Initial	Social Security Number	Date of Birth	Sex	Marital Status
Employee Mailing Address:						
Employer's Name:						
Date of Hire:		Date Employed Full Time:				

The Employee Benefit Plan is Providing Medical Coverage For:
☐ Employee Only ☐ Employee & Children
☐ Employee & Spouse Only ☐ Family

Name of Dependent	Relationship to Employee	Date of Birth	Present Height (ft.) (in.)	Present Weight (pounds)	Regular Physician & Phone No.

Section II – Life and Health Questions (This section must be filled out completely)

The employee must answer the following health questions. Please answer them fully and truthfully. Please understand that this is not an application for health insurance for you, your spouse and/or your dependents. Your employer is applying for medical stop loss insurance to insure against excess losses incurred by its self-funded employee benefit plan (The Plan) as listed above. The only way your employer can obtain this medical stop loss insurance is you report all health information being asked for on this questionnaire. No one is authorized to change this requirement in any manner. If there are any omissions or misstatements on this questionnaire, the medical stop loss coverage may be rescinded or reimbursement claims under the policy may be denied.

1. Is anyone named in this questionnaire:
   - A. Currently pregnant? (If yes, expected due date: _____)… ☐ Yes ☐ No
   - B. Any previous high risk pregnancy?……. ☐ Yes ☐ No
   - C. Currently taking any medications prescribed by a physician? (If yes, please list all medications below)…… ☐ Yes ☐ No
   - D. Now disabled or unable to perform normal work or age-related activities? (If yes, please identify names, conditions and dates of disability below)…… ☐ Yes ☐ No

2. Has anyone named in this questionnaire ever been diagnosed or tested positive as having an immune system disorder, including acquired immune deficiency syndrome, AIDS), or AIDS – related complex (ARC) only if diagnosed, or HIV virus?…… ☐ Yes ☐ No

3. Within the last five years, has anyone named in this questionnaire been advised or scheduled to have surgery or tests not yet completed…… ☐ Yes ☐ No

4. Within the last 10 years, has anyone named in this questionnaire been seen, counseled, consulted or treated for:

Yes	No		Yes	No	
☐	☐	Stroke, Circulatory Disorder, Heart Disease	☐	☐	Cancer, Tumor or Abnormal Growth
☐	☐	Connective Tissue Disorder	☐	☐	Intestinal Disorder
☐	☐	Emphysema, Lung Disease or Disorder	☐	☐	Seizures, Epilepsy
☐	☐	Liver Disorder	☐	☐	Anemia or Blood Disorder
☐	☐	Lupus	☐	☐	Multiple Sclerosis
☐	☐	Alcohol/Drug Abuse, Mental/Nervous disorder	☐	☐	Kidney, Bladder, Prostate Disorder
☐	☐	Arthritis, Back, Joint or Muscle Disorder	☐	☐	Uncontrolled/Complication of Diabetes
☐	☐	Menstrual/Gynecological Disorder, Infertility	☐	☐	Congenital Abnormalities
☐	☐	Organ / Tissue Transplant (past / pending)			

5. Within the last five years, has anyone named in this questionnaire had any mental or physical disorders, examination, hospitalization, treatment, medical advice or surgery not mentioned above? ☐ Yes ☐ No

IN THE SPACES BELOW, PLEASE LIST MEDICATIONS AND PROVIDE FULL DETAILS TO QUESTIONS FOR WHICH YOU ANSWERED, "YES" ABOVE. IF YOU NEED ADDITIONAL SPACE, PLEASE ATTACH A SEPARATE SHEET OF PAPER.

Question No.	Family Member	Dates of Treatment	Date of Full Recovery	Identify the Condition/Type of Treatment Received	Name/Phone # of Attending Physician

Disclosures, Authorization and Signature

I have answered the above questions to the best of my knowledge and belief. I understand and agree that no individual or group health insurance coverage will be issued to me, my spouse and/ or my dependents by Westport Insurance Corporation or Swiss Re as a result of my completion of this questionnaire. I further understand and agree that all medical coverage provided to me, my spouse and/or my dependents is or will be subject to the terms and conditions of the Employee Benefit Plan listed above.

I hereby authorize any physician, medical practitioner, hospital, clinic or other medical related facility, government agency, insurance company or other organization or person, that has any records or knowledge of me or any family member for whom coverage is provided under the aforementioned Employee Benefit Plan, to give Westport Insurance Corporation or Swiss Re or their representative(s) any such information. A photographic copy of this authorization shall be as valid as the original.

Signature of Employee _____ *Date Signed* _____