Group Medical Questionnaire

PARTNERS IN BENEFIT PLANNING, INC.

2000 S.E. 15TH Street, Building 400-E, Edmond, OK 73013

PHONE (405) 330-4015 **FAX (405) 330-1917**

Medical Profile

Plan sponsor: Please answer the following question *to the best of your knowledge* for all eligible employees, retirees & COBRA participants and their dependents. Provide details to questions answered "Yes" in the spaces below.

A) Have any claims greater than $5,000 been paid in the last two (2) years? ☐ Yes ☐ No

B) Within the past two (2) years, has any employee or dependent had a serious illness including, but not limited to, cancer, heart disease, diabetes, substance abuse, mental illness, AIDS or any immune deficiency disease, spina bifida, kidney disease, cystic fibrosis or any other progressive disabling illness? ☐ Yes ☐ No

C) Are any employees or dependents pregnant? ☐ Yes ☐ No If "Yes" how many and due date(s)?

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If you answered "Yes" to questions A or B, please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medications	$ Amount of Prior Claims	Prognosis/Current Treatment

The information on this form is designed to assist in Partners' evaluation of your group. The Prospective Applicant hereby certifies the information on this form is complete and true to the best of his/her knowledge.

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Prospective Applicant Name and Title (Please Print) Prospective Applicant Signature Date