Aetna™

Small Group Business
Group Medical Questionnaire

Instructions:

- This form to be completed by Employer.
- Please note: Groups with no prior fully-insured group coverage, a newly-formed business or with a lapse in coverage of greater than 63 days must complete the Individual Health Questionnaire.
- Any individual requesting Basic Life benefits greater than the Guarantee Issue level must complete the Individual Health Questionnaire.

Group Information

Name		
Address (include City, State, Zip Code)	Telephone Number	Federal Tax ID Number

To the best of your knowledge, answer the following questions for all enrolling employees, proprietors, partners, corporate officers, state or federal continuation coverage covered under your present plan. The information on this form is designed to assist in Aetna's evaluation of your group.

In the past three (3) years has any person enrolling consulted a health care provider, received treatment (including prescription medications) or been hospitalized for any of the following conditions, disorders or diseases

	Yes	No
1. **Heart and Circulatory Disorders:** heart attack, heart surgery, chest pain, heart murmur, stroke, high blood pressure, high cholesterol.	☐	☐
2. **Brain and Nervous System Disorders:** seizures, paralysis, multiple sclerosis, migraine headaches, depression/anxiety.	☐	☐
3. **Cancer/Tumors:** any form of cancer or tumor, any surgery, radiation or chemotherapy for cancer.	☐	☐
4. **Endocrine Disorders:** diabetes, lupus, chronic fatigue, thyroid disorders, immune disorders, AIDS/ARC	☐	☐
5. **Respiratory Conditions/Disorders:** asthma, emphysema, pneumonia.	☐	☐
6. **Intestinal/Digestive Disorders:** gastric reflux disease, liver failure, hepatitis, gallbladder disease, colitis, hernia.	☐	☐
7. **Musculoskeletal Disorders:** herniated disks, neck/back strains, joint replacement, arthritis, knee or shoulder injury, carpal tunnel.	☐	☐
8. **Congenital Disorders:** heart defects, cleft palate, Down's Syndrome.	☐	☐
9. **Kidney Disorders:** Kidney failure, dialysis, kidney stones.	☐	☐
10. **Skin Disorders:** psoriasis, basal cell carcinoma, melanoma.	☐	☐
11. Is any enrollee or dependent currently pregnant?	☐	☐
12. Is any enrollee or dependent undergoing treatment for infertility?	☐	☐
13. Is any enrollee or dependent an **organ transplant** recipient or candidate for transplant?	☐	☐
14. Has any enrollee or dependent been hospitalized or had any surgical procedures in the past 2 years?	☐	☐
15. Has any enrollee or dependent sustained any physical injury for which they are still under treatment?	☐	☐
16. Has any enrollee or dependent been advised to undergo further diagnostic testing, surgical procedures or hospitalizations?	☐	☐
17. Has any enrollee or dependent been treated or hospitalized for drug or alcohol abuse in the past 5 years?	☐	☐
18. Is any enrollee or dependent currently receiving Workers Compensation or Disability income?	☐	☐

For any "yes" answers provided in the above section, list the details for each "yes" answer in the section below: Use additional paper if necessary.

Question No.	Age	Condition/Disorder	Type of Treatment	Begin Date	End Date	Medications	Tobacco User (Yes or No)

I, as an Officer of this Company named above, certify that, to the best of my knowledge the information I have furnished is complete and accurate and includes all enrollees and dependents applying for coverage. I understand that material misrepresentations or willful omissions on this form may result in the cancellation of insurance.

Signature	Title	Date

NOTE: ***This form must be completed and signed by an officer of the company and is subject to review and approval by the Aetna Small Group Underwriting Department.***

Agent Name:	Agent Signature	Date