Physicians' Alliance Health Plan Trust
A Physician Owned Nonprofit Health Plan

Personal Health Questionnaire

Step 1 Employer Information

Group Name/Policy # ______________________

Date of Hire ______________________

Position Title ______________________

Hours Worked per Week ______________________

Annual Income ______________________

Reason for Application:

- O New Group Plan
- O Life Event/Date________
- O Status Change ________
- O Dependent Add/Delete
- O Change Name/Address
- O Waiving Coverage
- O Termination
- O New Hire
- O Annual Open Enrollment
- O Late Enrollee
- O Change in Coverage
- O Other ______________

Employee Type:

- O Active
- O COBRA
- O State Continuation
  - Start Date: / /
  - End Date: / /
- O Other ______________
- O Hourly
- O Salary
- O Union
- O Non-Union
- O Retired

Step 2 Employee Information

Name ______________________ *Last* *First* *MI*

Social Security # ______________________

Address ______________________

Cell # ______________________

City, State, Zip Code ______________________

Work # ______________________

Email ______________________

Sex O M O F Height __________ Weight __________

Birth date __________ *mm/dd/yyyy*

Used tobacco in the last 12 months? O Y O N

Preferred Language __________ *If not English*

Physician ______________________ *First & Last Name* *Phone #*

Primary Care Dentist ______________________ *First & Last Name* *Phone #*

Marital Status *Check correct status* O Single O Married O Divorced O Widowed

Step 3 Family Information

List all enrolling (attach sheet if necessary).

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F
Social Security Number *Height* *Weight* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F
Social Security Number *Height* *Weight* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F
Social Security Number *Height* *Weight* *Primary Dentist Name*

Last Name *First Name* *MI* *Birth date (mm/dd/yyyy)* *Relationship* Tobacco user? O Y O N Sex O M O F
Social Security Number *Height* *Weight* *Primary Dentist Name*

Waiver of Dependent Coverage (if none listed above), for dependents eligible under this plan: I realize that I can include my dependent(s) for consideration within my proposed coverage at this time but have chosen to exclude them. I understand that hereafter I may apply for dependent coverage only during an open enrollment period for my Plan or if a qualifying event occurs as defined in the Plan's Summary Plan Description.

Step 4 Medical Information

○ Cancer

Did your cancer require (check):

○ Surgery
○ Chemotherapy
○ Radiation

Is additional treatment planned? ○ Y ○ N

Location and Type

Stage

Date of Remission (if applicable)

Date of Last Treatment

Date of Next Treatment (if applicable)

○ Cardiac or Heart Disease

If yes, check all that apply:

○ Heart Attack
○ Bypass Surgery/Angioplasty
Single Vessel
○ Bypass Surgery/Angioplasty
Multiple Vessels
○ Hardening of the Arteries
○ Heart Valve Disorder
○ Heart Murmur
○ Angina

List ANY other heart conditions:

○ Kidney Disease

i.e. Nephritis, Renal Insufficiency, Kidney Failure, Proteinuria, Hematuria, Kidney Stones, Chronic Kidney Infections, Kidney Cysts

Are you on dialysis? ○ Y ○ N

Are you being considered for a kidney transplant? ○ Y ○ N

○ Substance Dependency

i.e. Alcoholism, Pain Medication Abuse, Opioid Abuse, Drug or Illegal Substance Abuse

Have you required treatment or hospitalization? ○ Y ○ N

○ Liver Disease

i.e. Cirrhosis, Hepatitis (A, B, C, E), Fatty Liver, Gall Bladder Disease

Are you diagnosed with chronic Hepatitis C? ○ Y ○ N

○ Circulatory System Disease

i.e. Stroke, Arterial/Vascular Diseases, Peripheral Vascular Disease, Aneurysm, Varicose Veins

○ Anemia, Bleeding/Blood System Disorders, or Hemophilia

○ Mental Illness

i.e. Depression, Anxiety, Bipolar Disorder, Schizophrenia, ADD, Eating Disorder, PTSD

Do you receive regular counseling or treatment? ○ Y ○ N

Have you had any hospitalizations related to mental illness? ○ Y ○ N

○ Immunodeficiency

i.e. Agammaglobulinemia, Common Variable Immunodeficiency, Hypogammaglobulinemia

○ HIV or AIDs
If yes, when were you diagnosed?

○ Respiratory/Sinus Disease

i.e. Bronchitis, Sinus Disease, Allergies, Chronic Cough, Pneumonia, Emphysema, Cystic Fibrosis

○ Asthma or COPD

If yes, how often do you use your emergency inhaler?

_____ times per day
_____ times per week

Are you on daily control medication? ○ Y ○ N

○ High Blood Pressure

If yes, list 3 most recent readings:

1.
2.
3.

○ Nervous System Disorders

i.e. Seizures, Epilepsy, Migraine Headache, Carpal Tunnel Syndrome, Parkinson's Disease, Bell's Palsy Encephalitis, Muscle Weakness, Paralysis, Fibromyalgia

○ Autoimmune Disease

i.e. Lupus, Multiple Sclerosis, Myasthenia Gravis

If yes, what type?

○ Back Disorder/Chronic Back Pain

i.e. Degenerative Disk Disease, Herniated Disk, Spinal Fusion, Spondylitis Strain

○ Muscular Disorder

i.e. Muscular Dystrophy, Myalgia, Myositis, Muscular Atrophy

○ Benign Growth

i.e. Tumor, Cyst

○ Chronic Pain Syndrome

○ Diabetes

If yes, list type 1 or 2 & three most recent HbA1c/fasting blood sugar levels in spaces below:

Type:

1.
2.
3.

Do you have any eye, kidney, nerve, or chronic ulcers from diabetes? ○ Y ○ N

○ Bowel & Digestive System Disorders

i.e. Colitis, Regional Enteritis, Caclulus of Galbladder, Ulcerative Colitis, Crohn's Disease, Pancreatitis, Celiac Disease, Diverticulitis, Irritable Bowel Syndrome, Colostomy

○ Endocrine Disorders or Metabolic Disorders

i.e. Lipidosis, Amyloidosis, Thyroid Disease, Graves Disease, Growth Hormone Deficiency, Adrenal Disease, Cystic Fibrosis

○ High Cholesterol

If yes, list 3 most recent readings:

1.
2.
3.

○ Congenital Abnormalities or Newborn Complications

i.e. Cleft Lip or Pallet, Heart Anomalies, Down's Syndrome, Spina Bifida, Muscular Dystrophy

○ Stomach

i.e. Ulcer Disease, Reflux Disease, Heartburn, Hiatal Hernia, Abdominal Pain, Barrett's Esophagus

○ Bariatric Procedures

i.e. Weight Loss Surgery, Stomach Stapling, Roux en Y, Sleeve Gastrectomy

○ Transplants

If yes, list organs:

○ Intracranial, Spinal Cord, or Paralysis Injuries or Disorders

○ Major Trauma, Amputation, or Burns

○ Arthritis

i.e. Rheumatoid, Osteo, Psoriatic, Gout

Additional Questions & Detail Table

If answered yes to any questions on previous page or below, please use table at bottom of page to provide details.

Check any currently existing conditions listed below for enrolling members:

- ○ Taking prescription medications
- ○ Hospitalized or confined to a treatment facility
- ○ Confined at home, incapacitated, or incapable of self-support

Check all that apply for anyone with a serious illness in the past 5 years:

- ○ Treatment (medical treatment or diagnostic testing)
- ○ Hospitalization
- ○ Surgery

Has anyone enrolling had symptoms of any serious medical condition in the past 5 years not yet indicated on this form? ○ Y ○ N

Check any pending items listed below for enrolling memebers:

- ○ Treatment (medical treatment or diagnostic testing)
- ○ Hospitalization
- ○ Surgery

Are any enrolling members pregnant? ○ Y ○ N
If answered yes, please provide the following details:

Due Date

Is this a high risk pregnancy? ○ Y ○ N

Are there any prior c-sections or pre-term births? ○ Y ○ N

Are multiple births expected? ○ Y ○ N
If yes, check one of the following: ○ twins ○ triplets ○ more

Name of Individual			Condition/Diagnosis	Onset Date	Last Date Treated	Degree of Recovery	Treatment/Drug	Still Taking?
								○ Y ○ N
Last	*First*	*MI*						○ Y ○ N
Last	*First*	*MI*						○ Y ○ N
Last	*First*	*MI*						○ Y ○ N
Last	*First*	*MI*						○ Y ○ N
Last	*First*	*MI*						○ Y ○ N

In the event that information submitted on this form constitutes fraud or there is an intentional misrepresentation of the material fact, the plan may rescind coverage, for either the individual or the entire group. In any such case, I understand that the plan will return any contributions that have previously been paid as to the rescinded coverage. I certify that the statements are true and correct to the best of my knowledge. I understand that this form is used for information only and does not bind coverage.

PAHPT gathers this information for statistical and actuarial use only. This information is not to be used in connection with any decisions or actions regarding any individual's employment. Prospective employees in Michigan should not provide information regarding height or weight. In compliance with requirements for GINA, PAHPT is not requesting genetic information.

PAHPT Program Notice of Privacy Practices provides more detailed information about how PAHPT Program and the health plan I have chosen may use and disclose my protected health information. I have a legal right to review this Notice of Privacy practices before I sign this consent and I am encouraged to read it in full. I have a right to request restrictions on how my protected health information is used and disclosed. The PAHPT Program and my health plan are not required by law to grant my request. However, if my request is granted, the PAHPT Program and my health plan are bound by their agreement. I have a right to revoke this consent in writing, except to the extent the PAHPT Program or my health plan have already used or disclosed my protected health information in reliance upon my consent. I will notify PAHPT of any health or enrollment related changes that occur after signing this form up to the effective date of coverage on the health plan.

Applicant PRINT:_____ Applicant SIGNATURE:_____ DATE: / /