Health Net® *Pacific Health Trust*

Individual Health Risk Questionnaire *(HRQ)*

Instructions: The questions below apply to each employee and dependent(s) that are applying for coverage listed on this application. They apply to both past and present conditions or symptoms. Answer each question truthfully and completely. Attach a piece of paper if you need more space. Complete every item, even if the answer is "No." We consider the answer to each question to be material to the risk Health Net assumes in extending health care coverage. Applications will be returned if any question is not answered completely.

Genetic Information Non-discrimination Act of 2008 (GINA) Compliance Statement: This Health Risk Questionnaire (HRQ) is not a request for genetic information. In answering these questions, you should not include any genetic information. That is, please do not include any family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic disease for which you believe you may be at risk.

Part I. Applicant(s) information

Company name: ____________________

	First name Last name	Sex M/F	Date of birth	Height	Weight (lbs.)	Tobacco use within last 12 months?	Name of primary physician	Physician's phone number
Employee						☐ Yes ☐ No		
Spouse/ State Reg DP[1]						☐ Yes ☐ No		
Child(ren)						☐ Yes ☐ No		
						☐ Yes ☐ No		
						☐ Yes ☐ No		

Part II. (a) Statement of Health

Please check any condition, treatment or care mentioned below that applies. All questions must be answered. For "Yes," please provide detail in Part III.

Indicate if you or any listed dependents have ever suffered from, or received care, counseling or been advised for, any of the following:

		Primary applicant	Dependent 1	Dependent 2
1)	Alcohol/drug use or abuse	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2)	AIDS/HIV or ARC	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
3)	Back or spine disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4)	Cancer or tumor	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
5)	Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6)	Digestive/bowel disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

(continued)

[1]State Registered Domestic Partner

Part II. (a) Statement of Health (continued)

		Primary applicant	Dependent 1	Dependent 2
7)	Heart condition	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8)	Immune system disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9)	Kidney/renal disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
10)	Liver disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
11)	Ulcer	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
12)	Hypertension	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
13)	Mental disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
14)	Neurological disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
15)	Paralysis/stroke	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
16)	Respiratory/lung disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
17)	High blood pressure	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
18)	Last reading (systolic/diastolic):			

Female applicant(s) only

Is female applicant, spouse, State Registered Domestic Partner or any dependent now pregnant? ☐ Yes ☐ No

If "Yes," name and relationship: ____________________ Due date: ____________

		Primary applicant	Dependent 1	Dependent 2
19)	Are complications anticipated?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
20)	Multiple birth?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
21)	Prior history of miscarriage, therapeutic abortions, stillbirth, cesarean section or other complication of pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
22)	Any congenital anomalies or health complications with previous newborns?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
23)	Any congenital anomalies or health complications with current fetus?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
24)	Any problems, including vaginal bleeding, with pregnancy?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

All applicant(s)

		Primary applicant	Dependent 1	Dependent 2
25)	Have any applicant(s) been counseled or advised that they have or may have any disease, disorder, impairment, deformity, injury or any chronic or untreatable condition whether active or in remission?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
26)	Have any applicant(s) had medical or surgical consultation, advice or treatment (including medication) for any condition(s) during the past 36 months?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

(continued)

Part III. (b) Statement of Health

If you have checked "Yes," for any item in Part II, please explain below (use additional sheet of paper if necessary).

Patient's name	Diagnosis/condition requiring treatment	Treatment	Physician	Physician's phone number	Date of illness (mm/yy)	Was recovery complete?
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No

Have you or any listed dependents taken or used any medication or drug within the past 12 months? ☐ Yes ☐ No
If "Yes," please explain below. (Use extra sheet of paper if necessary.)

Patient's name	Medication name	Condition requiring medication	Still taking?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

		Primary applicant	Dependent 1	Dependent 2
1)	Has the applicant or any listed dependent ever been denied insurance coverage? If "Yes," please explain below:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2)	Do you and your dependents currently have comprehensive coverage under another health plan? If "Yes," please attach copies of current enrollment cards to this form.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

I hereby declare that the foregoing is true and correct to the best of my knowledge. This declaration is made under the penalty of perjury of the laws of the State of Washington. **I understand that fraud or intentional misrepresentation of material fact, in order to obtain coverage, may result in termination of coverage.**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee name (please print)	Signature	Daytime phone #	Date
		( )	