Employee Health Coverage Questionnaire

Name: ____ Social Security #: __________________

Date of Birth: _____________ Male / Female (circle one) Height: ____ Weight: ____ Smoker: Yes / No (circle one)

Present Address: ____

Home Phone: _________________ Work: _________________ Email Address: ___________________________

Medical Information

1. Do you or your dependents regularly take Medication? Yes ☐ No ☐

2. Has a Physician told you or any of your dependents that surgery or special tests or treatment may be necessary in the future? Yes ☐ No ☐

3. Are you or any of your dependents currently pregnant? Yes ☐ No ☐
   If yes, person's name __________Due date ____/____/____ .

4. In the last 5 years have you or any of your dependents been diagnosed or treated or any: heart/circulatory condition; cancer/tumor; disorder of the blood or immune system; stroke, aneurysm, AIDS or HIV, diabetes (list age at onset date below); mental/nervous disorder; depression, alcohol or drug abuse/dependency; kidney, liver or pancreas disorder; ulcerative colitis; Crohn's disease; lupus; lung disorder; COPD; emphysema; arthritis; back/disk disorder; multiple sclerosis; or muscular dystrophy? esY ☐ No ☐

EXPLAIN ALL "YES" ANSWERS TO ANY QUESTION ABOVE. PLEASE BE SURE TO INCLUDE TREATMENT DATES. (Attach a separate sheet of paper if necessary). If treatment is "ongoing", please write in "ongoing" under "treatment ends" block.

Question #	Name of Individual	Diagnosis	Treatment	Medication	Date Treatment Started	Date Treatment End(s)	Hospitalized and/ or Surgery IF Yes, detail	Physician Name

I represent that all answers to questions on this form are true and accurate to the best of my knowledge regarding dates, medication taken, and all other treatment received. I understand misstatements or failures to report new medical information prior to my effective date may result in a material change to coverage or premium. (FOR PRIVACY NOTICE, PLEASE VISIT OUR WEBSITE AT WWW.LANDMARKINSURE.COM)

Signature: ____________________________________ Date: _______________