Pre-Application Health Insurance Form

(Please save this document to your computer before continuing to fill in requested information.)

Agent Name: Walter E. Jamison
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Email: walter@speedyisp.net Fax Back to: (785) 830-9322

Applicant/Person to be Covered for Child Only

Last Name: ______ First Name: ______ Initial: ______

Home Address: ______ City: ______ State: ______ Zip: ______
(P.O. Box, Not acceptable)

County: ______ Home Phone: ______ - ______ - ______ Best time to Call: ______

Gender: ☐ M ☐ F Date of Birth: ______ (**/**/****) Height: ______ Weight: ______ ☐ Single

☐ Yes ☐ No Are you a U.S. Citizen? If no, list how long in U.S.: ______ ☐ Married

Dependent Enrollment Information

Spouse (First Name & M.I., last name if different): ______
Gender: ☐ M ☐ F Date of Birth: ______ (**/**/****) Height: ______ Weight: ______

Child (First Name & M.I., last name if different): ______
Gender: ☐ M ☐ F Date of Birth: ______ (**/**/****) Height: ______ Weight: ______

Child (First Name & M.I., last name if different): ______
Gender: ☐ M ☐ F Date of Birth: ______ (**/**/****) Height: ______ Weight: ______

Child (First Name & M.I., last name if different): ______
Gender: ☐ M ☐ F Date of Birth: ______ (**/**/****) Height: ______ Weight: ______

Dependents (19 up to 25) attending school full-time, including name of dependent, name/address of school, and number of credits: ______

Eligibility

☐ Yes ☐ No Are you or any family member covered by Medicare? If yes, list family members and their effective date: ______

☐ Yes ☐ No Are you, any family member, or significant other pregnant or in the process of adoption or surrogacy (including those not applying for coverage)? ______

☐ Yes ☐ No Are you or any eligible dependent disabled, receiving disability payments, or hospital confined? ______

☐ Yes ☐ No Do you intend to replace, discontinue, or terminate an existing life policy? If yes, please provide previous insurance company name & current premium costs. ______

Medical History

A. Within the past five years, has any person to be insured ever had any symptoms that would cause an ordinary prudent person to seek medical care; had any conditions, diagnosis, consultation, routine follow-up, treatment, or therapy; been prescribed any medication; been monitored; or received counseling for any of the following?... (Provide details to "Yes" answers below.)

1) Digestive Disorder	Yes	No
a. Irritable Bowel, Spastic Colon	☐	☐
b. Colitis, Crohn's Disease	☐	☐
c. Gastric Reflux, Heartburn	☐	☐
d. Gallbladder Disease	☐	☐
e. Hepatitis, Other Liver Disorder	☐	☐
f. Other Digestive or Intestinal Disorder	☐	☐

2) Cardiovascular/Circulatory	Yes	No
a. High Blood Pressure, Hypertension	☐	☐
b. Mitral Valve Prolapse, Heart Murmur	☐	☐
c. Chest Pain, Heart Attack, Arrhythmia, Angina, Palpitations	☐	☐
d. Vascular Abnormality, Poor Circulation	☐	☐
e. Stroke, Transient Ischemic Attack	☐	☐
f. Other Heart Condition or Disease	☐	☐

3) Respiratory/ Lung	Yes	No
a. Allergies, Asthma	☐	☐
b. Bronchitis, COPD, Emphysema	☐	☐
c. Sleep Apnea, Tuberculosis	☐	☐
d. Other Respiratory or Lung Disorders	☐	☐

4) Musculoskeletal/Nerve	Yes	No
a. Arthritis or Rheumatism, Carpal Tunnel	☐	☐
b. Neck, Back, Spinal Condition	☐	☐
c. Bone, Muscles, Joint Condition	☐	☐
d. Fracture, Dislocation, Internal Fixation	☐	☐
e. Lupus, Connective Tissue Disease	☐	☐
f. Osteoporosis, Osteopenia	☐	☐

5) Cyst/Tumor/Polyp/Malignancy	Yes	No
a. Cancer, Leukemia	☐	☐
b. Cyst, Growth, Lump, Tumor, Polyp	☐	☐
c. Hodgkin's or Non-Hodgkin's Lymphoma	☐	☐

6) Genitourinary	Yes	No
a. Fibrocystic Breast, Implants, Other Breast Conditions	☐	☐
b. Ovarian Cyst, Uterine Fibroid	☐	☐
c. Infertility Testing or Treatment	☐	☐
d. Menstrual. Reproductive Organ Disorder	☐	☐
e. Abnormal Pap Smear	☐	☐
f. Prostrate Gland Disorder, Abnormal PSA Test	☐	☐
g. Sexually Transmitted Disease	☐	☐
h. Urinary Tract, Bladder, Kidney Disorder	☐	☐

7) Eyes/Ears/Nose/Throat/Skin	Yes	No
a. Acne, Skin Disorder	☐	☐
b. Ear, Nose, Sinus, Throat, Mouth	☐	☐
c. Eye, Cataracts, Glaucoma, Other	☐	☐
d. Loss of Hearing, Deafness	☐	☐
e. Jaw Condition or TMJ	☐	☐
f. Vision Impairment, Blindness	☐	☐

8) Endocrine/Gland/Lymph/Blood	Yes	No
a. Blood Abnormality, Anemia	☐	☐
b. Elevated Cholesterol/Triglycerides	☐	☐
c. Diabetes, Pancreas, Elevated Glucose	☐	☐
d. Hormonal Disorder, Adrenal	☐	☐
e. Lymph Gland Disorder, Thyroid, Goiter, Immune System	☐	☐

9) Alcohol/Drug	Yes	No
a. Alcoholism, 3+ Alcoholic Drinks/day	☐	☐
b. Drug or Substance Abuse, Illicit Use	☐	☐

10) Psychological	Yes	No
a. Anxiety, Panic Disorder	☐	☐
b. Depression, Major Depressive Disorder	☐	☐
c. Bipolar Disorder	☐	☐
d. Obsessive Compulsive Disorder	☐	☐
e. Schizophrenia, Schizoaffective Disorder	☐	☐
f. Anorexia, Bulimia Nervosa	☐	☐
g. Other Psychological Condition	☐	☐

11) Neurological	Yes	No
a. Cerebral Palsy, Muscular Dystrophy	☐	☐
b. Epilepsy, Seizures, Convulsions	☐	☐
c. Headaches, Migraines	☐	☐
d. Mental Retardation, Down's Syndrome	☐	☐
e. Multiple Sclerosis, Paralysis	☐	☐
f. Other Neurological Disease or Disorder	☐	☐
g. Alzheimer's Disease, Dementia	☐	☐
h. Parkinson's Disease	☐	☐
i. Autism, Pervasive Develop. Disorder	☐	☐

12) General	Yes	No
a. Abnormal Test Results	☐	☐
b. Burns, Edema, Hernia, Ulcer	☐	☐
c. Congenital Abnormality, Loss of Limb	☐	☐
d. Fibromyalgia, Chronic Fatigue	☐	☐
e. Organ/Tissue Transplant or Surgical Implants	☐	☐
f. Pain Disorder or Chronic Infection	☐	☐

Provide details to "YES" answers here.

Question#/Letter	*Name*	*Illness/Impairment*

(See page 4 for more space for answer details if needed.)

Medical History Continued

B. ☐ Yes ☐ No In the past five years, have you or any eligible dependent ever been declined, postponed, ridered, rescinded, or rated up for medical, disability, critical illness, life insurance, or long term care with another insurance carrier? If yes, explain: ______

C. ☐ Yes ☐ No In the past five years, have you or any person to be insured received treatment, received therapy, taken medication, or consulted a health care provider for any reason? If yes, explain: ______

D. ☐ Yes ☐ No Are you or any person to be insured currently taking any prescription medications, over-the-counter medications, vitamin therapy or alternative remedies (including herbs)? Please list medications and indicate the reason for use: ______

E. ☐ Yes ☐ No In the past five years, has any person to be insured been advised to have a test or treatment, been advised to obtain equipment or service, been advised of a condition that may require attention or treatment, or are you awaiting the results of any medical tests or investigation? Explain: ______

F. ☐ Yes ☐ No Within the past five years, has any person to be insured been advised to seek treatment for or been advised to limit alcohol or drug use, been a member of any alcohol or drug support group or used any controlled drug not prescribed by a doctor? If yes, explain: ______

G. ☐ Yes ☐ No Has any person to be insured ever been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a physician or member of the medical profession, or tested positive for HIV? If yes, list names: ______

H. ☐ Yes ☐ No Has anyone to be insured used tobacco products during the previous 12 months? If yes, list names: ______

Prior Coverage

☐ Yes ☐ No Are you or any dependents replacing health insurance coverage that was in effect within the the last 63 days? If yes, please state company and premium: ______

☐ Yes ☐ No Do you or any dependents to be insured have or intend to keep any health insurance coverage, including COBRA and/or state continuation currently in force? If yes, please state coverage and cost if any: ______

Provide More Details to "YES" Answers Here

Question#/Letter	*Name*	*Illness/Impairment*