



Medical Questionnaire Individual Profile

General Instructions

Please complete all of the questions on both sides of form. It is important to sign and date the form after you complete all questions. (If you need additional room, please include a separate piece of paper). For confidentiality purposes, please seal in a separate envelope and address to: Zogg Insurance Services, Underwriting Dept., 17304 Preston Rd., Suite 260 , Dallas, TX 75252.

To protect your confidentiality, your individual profile will only be reviewed by designated Zogg personnel and will not be shared with other Zogg personnel or your employer.

You may be contacted by designated Zogg personnel should additional information be required during the review process. Please provide a phone number at which you can be reached during business hours:

(_____) _____ - _____ .

General Information

Employer			
Last Name		First Name	MI
Social Security Number	State	Zip Code	

Individuals To Be Enrolled in Zogg's Medical Plan

List below only those persons to be enrolled for medical coverage	Gender (Circle one)	Relationship (To Applicant)	Birthdates (MM/DD/YY)	Height (Ft. In.)	Weight (Lbs.)
APPLICANT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				
DEPENDENT (Full Name)	M F				

Medical History

Please circle your response. During the last 5 years, have any of the individuals to be enrolled had or been told they have the following conditions:

YES	NO	1. Cancer or tumor Stage when diagnosed: _____
YES	NO	2. Neurological or Congenital Disorder
YES	NO	3. Diabetes - last 3 sugar dates & readings A. ___/___/___ B. ___/___/___ C. ___/___/___
YES	NO	4. Heart condition, High Blood Pressure or Stroke
YES	NO	5. Digestive Condition
YES	NO	6. Lung Condition
YES	NO	7. Bone/Joint Condition
YES	NO	8. Immunological Disorder
YES	NO	9. Organ Condition
YES	NO	10. Other condition not mentioned above
YES	NO	11. Are YOU or any DEPENDENTS listed herein now pregnant? If yes, due date : _____ / _____ / _____
YES	NO	11a. Are you aware of any complications, multiple births, etc.
YES	NO	12. Have you or anyone enrolling in medical coverage been hospitalized or had surgery in the past 5 years?
YES	NO	13. Do you or anyone enrolling in medical coverage anticipate any hospitalization, surgery or treatment within the next year?

Medical History Details

Please provide details below for all questions to which you answered **yes** above. Be sure to indicate each question answered by number.

#	Specific Condition	Patient Name	Treatments/Prescriptions	Onset Date	Duration	Current Status

Other Prescription Details

Please list the details of any other prescription medications taken that are **not** listed above.

Patient Name	Prescription Name	Dosage (if known)	Reason for Prescription	Date Originally Prescribed

Certification and Confidentiality Statement

I hereby certify that the above statements and answers are complete and true to the best of my knowledge and belief concerning the past and present state of health and medical history of the person(s) to whom the statements and answers relate. This information is considered private and confidential and will not be shared or released to any third parties, including the life or health insurance carriers or my current employer. This information will remain the property of Zogg Insurance Services and will constitute a part of the coverage contract. Any misstatements or failure to report information on this form regarding your current conditions/treatments or past medical history may be used for rescission of your coverage.

Print Name

Signature

Date