



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 |
|---|--------------------|--------------|--------------------------|------------|----------|----------------|
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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 |
|--------------|-------------------|-------------------|-------------------------|----------------------------|
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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 _____