

Group Employer Medical Questionnaire

Blue Cross and Blue Shield of Oklahoma P.O. Box 3283 Tulsa, OK 74102-3283

Complete the following questions to the best of your knowledge for eligible employees, their dependents, and any COBRA participants, state continuation participants, or state dependent continuation participants. If your current carrier is Blue Cross and Blue Shield of Oklahoma, your response to the medical questions should be based on eligible employees and/or dependents not currently on your employee group health plan. If BCBSOK is your current carrier, provide your Group/Account Health Number.

- 1. How many employees or dependents have had a claim of \$5000 or more in the past 12 months?
- 2. How many employees or dependents have been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? _____
- 3. How many employees or dependents have been advised, diagnosed, or treated by a physician in the past 5 years for (Enter the **number** of employees or dependents with the condition and provide details on the next page.):

A	Stroke Heart Disease or Disorder Circulatory Disease or Disorder	Vascular Disease or Disorder High Blood Pressure
B		Lupus Chronic Skin Condition Any other Systemic Disease
C	Multiple Sclerosis Paralysis Osteoarthritis Other Severe Arthritis	Joint Disorders Back Disorders Muscle Disorders Bone Disorders
D	Asthma Emphysema	Respiratory and Lung Disorders
E	Diabetes Pancreas	Growth Disorder Endocrine Disorder
F	AIDS Tested Positive for HIV	Immune System Disorders Blood Disorders
G	Hepatitis Liver Disorder Digestive System Disease or Disorder Colon Disorder	Kidney Disorder Prostate Disorder Reproductive Organ Disorder Infertility Urinary Tract Disorder
H	Nervous System/Brain/ Seizure Disorders Mental/Emotional Disorders	Alcohol/Drug/Substance Abuse or Dependency
I	Organ Transplant	Bone Marrow Transplant
J.	Other	

4. How many employees or dependents are currently pregnant?

If you have indicated medical conditions on the previous page, please provide details for each person with the condition. If more than one person has the condition, add a separate entry for each person. See the example in the first line.

Age	Gender	Relation to Insured*	Condition/ Diagnosis Details	Treatment/ Medication Details	Date(s) Treated	Current Status
12	М	Child	Appendicitis	Surgery to remove appendix	01/01/99 to 01/05/99	Full recovery
			Insured*	Insured* Diagnosis Details	Insured*Diagnosis DetailsMedication Details12MChildAppendicitisSurgery to remove	Insured*Diagnosis DetailsMedication DetailsTreated12MChildAppendicitisSurgery to remove01/01/99 to

* Employee, Spouse, Child

I understand the information on this form and any other medical information provided to BCBSOK in prior preliminary medical requests or otherwise provided to BCBSOK, is the basis for premium determination by BCBSOK for the health plan. I acknowledge that false statements or material misrepresentations may result in legal consequences. I certify the information is complete and true to the best of my knowledge.

Authorized Company Official's initials here: _____ Agent's initials here, if applicable: _____