



Cox Health Systems Insurance Company

LISTED BELOW ARE THE SUPPLEMENTAL QUESTIONNAIRES THAT MAY BE USED TO OBTAIN ADDITIONAL INFORMATION ABOUT STATEMENTS MADE ON ANY APPLICATION FOR COVERAGE ON OUR PPO PLANS; GROUP OR INDIVIDUAL.

HEALTH CONDITION	TAB NAME	FORM #
Attention Deficit/Hyperactivity Disorder	ADD-Hyperact	CHSIC-HQ1
Alcohol Supplement	Alcohol supp	CHSIC-HQ2
Asthma/Respiratory (Allergies)	Asthma-Res	CHSIC-HQ3
Back/Spine	Back-Spine	CHSIC-HQ4
Cancer/Cyst/Polyp/Tumor	Cancer - Tumor	CHSIC-HQ5
Checkup Supplement	Checkup	CHSIC-HQ6
Chest Pain	Chest Pain	CHSIC-HQ7
Chronic Fatigue Syndrome - Epstein Barr	Chronic Fatigue	CHSIC-HQ8
COPD/Emphysema Supplement	COPD-Emphysema	CHSIC-HQ9
Coronary Artery Disease Supplement	Coronary Disease	CHSIC-HQ10
Diabetes	Diabetes Quest.	CHSIC-HQ11
Digestive	Diagestive Quest.	CHSIC-HQ12
Drug	Drug Quest.	CHSIC-HQ13
DUI Supplement	DUI Supp	CHSIC-HQ14
Endocrine/Thyroid/Diabetes	Endoc-Thyr-Diab	CHSIC-HQ15
Epilepsy / Seizure	Epil-Seiz	CHSIC-HQ16
Eye Disorder	Eye disorder	CHSIC-HQ17
Female Genital Disorder	Female Genital	CHSIC-HQ18
Fibrocystic Breast Disease	Fibro breast	CHSIC-HQ19
Headache/Migraine	Headache	CHSIC-HQ20
Heart Disorders	Heart Dis	CHSIC-HQ21
Hepatitis Supplement	Hepatitis	CHSIC-HQ22
High Blood Pressure	High blood	CHSIC-HQ23
High Cholesterol	High Chol	CHSIC-HQ30
Injuries	Injuries	CHSIC-HQ24
Joint / Arthritis	Joint-Arth	CHSIC-HQ25
Kidney/Bladder/Prostate	Kid-Blad-Pros	CHSIC-HQ26
Mental/Emotional Disorders	Mental-Emotional	CHSIC-HQ27
Pregnancy Supplement	Pregnancy	CHSIC-HQ28
Sports or Hobbies	Sports-Hobbies	CHSIC-HQ29

ATTENTION DEFICIT/HYPERACTIVITY DISORDER



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. When was diagnosis made? _____
2. What testing was done to make diagnosis and results of these test:

3. What medication is taken to control the condition? Frequency?

Any change in drug, and/or amount taken? _____
If so, describe when and what changes were made: _____

4. **In regards to Children:** Is this medication taken all year round or only during school year?

5. Has there been an improvement as the result of the medication? _____

6. Any learning disabilities and/or behavioral problems? _____
If so, describe: _____
Any symptoms of depression? _____ If answered yes, describe _____

7. Any psychological counseling required? _____ If so, when: _____
Frequency of visits: _____

How much longer and where: _____

8. Any hospitalization required? _____ If so, when: _____
How long and where: _____

9. What has the doctor told you about future follow-up required (I.e., frequency of visits, testing)?

10. What has the doctor told you about prognosis of the condition? _____

11. Name and address of medical doctor, psychologist, or social worker providing treatment:

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ALCOHOL SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

- 1. Have you ever been advised to decrease or to stop alcohol consumption? YES [] NO []
If so, who suggested this? _____
2. When did you last have and alcoholic beverage? _____
Type of alcohol and quantity consumer: _____
3. Has treatment for alcohol use been recommended or received? YES [] NO []
If recommended, who recommended it? _____
If received, by whom? _____

Was it psychiatric counseling, and/or a state/alcohol rehabilitation program? (Circle appropriate Response) If yes, name and location of facility and consulting physician if known: _____

The date(s) you were treated or attended the program? _____
Are you currently receiving treatment? YES [] NO []
Was it an inpatient or out patient program? _____
Were any medications taken? YES [] NO [] If answered yes, date last used? _____
List Medications: _____
Have you ever had a relapse? YES [] NO []
If answered yes, details _____

- 4. Have you ever been a member of Alcoholics Anonymous or any other support group?
YES [] NO []
If yes, how long have you participated? _____
Are you currently an active member? YES [] NO []
How often do you attend meetings? _____

- 5. Do you have any history of abnormal liver enzymes? YES [] NO []
If so, was treatment received and when? _____
Have liver enzymes returned to normal? YES [] NO []

- 6. Have you ever had any medical problems that resulted from or were present at the time you
received treatment for substance abuse? YES [] NO []
If yes, provide dates and details of problems and treatment: _____

Name and address of Dr. _____

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ASTHMA/RESPIRATORY (Allergies)



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. What is the name of the respiratory condition? _____
2. What is the date of the onset of the condition? _____
3. How frequently is a doctor consulted for the condition? _____

4.a) What medications are used: _____

b) How frequently: _____

5. Have steroids ever been prescribed? If so, please provide names and dates taken: _____

6. Is the condition symptomatic: occasionally _____ seasonally _____ year-round _____

7. Is the condition: mild _____ moderate _____ severe _____

8. has hospitalization for the condition ever been necessary or recommended? If yes, please provide dates and details: _____

9. Has any surgery ever been performed or recommended? If yes, please provide dates and details: _____

10. Doctor's name and address: _____

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BACK/SPINE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. What was the date of the onset of the back condition? _____
2. What was the cause of the back condition? _____
3. What is the nature of the back condition?
a) Disc problem (such as slipped or ruptured disc) _____
b) Other (describe fully) _____

4. What part of the back was affected?
a) Upper part of back (cervical area) _____
b) Middle part of back (thoracic or dorsal area) _____
c) Lower part of back (lumbar or sacroiliac area) _____

5. How long did this condition prevent you from performance of regular activities or occupational duties? _____

6. What treatment was given and what was the date of the last treatment? _____

7. How long has it been since symptoms last appeared? _____

8. if you still have symptoms, please describe the symptoms, including severity and frequency: _____

9. If traction, back support, brace, or belt was uses:
a) What type? _____
b) How long was it used? _____
c) Is it still used? _____
d) Date discontinued? _____

10. Is there any complicating condition such as spinal curvature, arthritis, etc.? If yes, give details: _____

11. Give details of any previous back trouble, including dates: _____

12. Has an operation for correction of the condition ever been suggested? If yes, give details: _____

13. Has hospitalization been suggested for necessary treatment? If yes, give details: _____

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CANCER/CYST/POLYP/TUMOR



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Type. If you know the class please state. _____
 2. If cyst or polyp, how many? _____
 3. Exact location: _____
 4. Is it still present? _____
 5. Surgically removed? _____
 6. Benign or malignant: _____
 7. If tumor or cancer, was there any metastasis? _____
 8. Type and dates of treatment: _____
-
9. Describe follow-up treatment: _____
 10. Any recurrence? _____
 11. Results of follow-up: _____
 12. Degree of recovery: _____
 13. Type of future treatment anticipated: _____
 14. Name and address of physician consulted for this condition: _____

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SIGNATURE OF PROPOSED INSURED

CHECKUP SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Date of consultation? _____
2. Give full name and address of doctor consulted _____
3. What were the complaints which prompted the consultation? (give details)

4. What was the diagnosis? _____
5. What did your doctor prescribe or recommend? _____
6. Did you undergo any special tests such as electrocardiogram, blood sugar investigation or X-Ray?
 - a) If X-ray was it for chest or otherwise? _____
 - b) What were the results? _____
 - c) List all special tests given, including dates and the results, if known. _____
7. Are you currently under any medical treatment? If so, give details.

8. Did the physician indicate any further investigation or checkup should be done?
If so, when? _____
9. Have you consulted any other physician with respect to this condition? If yes, give doctor's full name and address. _____
10. Please give full name and address of your family physician.

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CHEST PAIN QUESTIONNAIRE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Date of onset _____
2. Description of symptoms:
 - a. Sense of pressure or constriction? _____
 - b. Radiation of pain? _____
 - c. Sweating? _____
 - d. Shortness of breath? _____
 - e. Was it associated with exercise? _____

3. Diagnosis:
 - a. Myocardial Infarction YES NO
 - b. Angina Pectoris YES NO
 - c. Anxiety YES NO
 - d. Hiatal Hernia YES NO
 - e. Muscle Spasm YES NO
 - f. Pylorospasm YES NO
 - g. Other _____

4. Treatment or medication prescribed _____

5. Time lost from work. _____

6. Name of Physician or Hospital consulted. _____

7. Please give full name and address of your family physician _____

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Chronic Fatigue Syndrome- Epstein Barr (Circle One)



Cox Health Systems Insurance Company

Proposed Insured Name: _____

Dependent Name (if applicable) _____

Social Security # _____

A. Date of diagnosis _____

B. Name medication(s) currently taking _____

Any medication in the past? Yes No If yes, type and dates: _____

C. Frequency of counseling sessions _____

Date of last visit _____

D. Present condition _____

E. Degree of recovery _____

F. Have you ever been hospitalized for this condition? Yes No

If yes, provide details _____

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COPD/EMPHYSEMA SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

- A. Medical condition (diagnosis) _____
- B. Date of onset/diagnosis _____
- C. Type and date of treatment _____
- D. Describe any current symptoms _____

- E. Have you ever had any of the following:
- | | |
|--|--|
| <input type="checkbox"/> Frequent respiratory infections | <input type="checkbox"/> Heart enlargement |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cough |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chest tightness |

F. Describe restrictions in activity _____

- G. Have you ever been hospitalized? Yes No
If yes, reason and dates _____

H. Are you currently smoking? Yes No
If yes, number per day _____

- I. Do you/have you ever used a mechanical breathing aid?
 Yes No If yes, type of aid used? _____

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CORONARY ARTERY DISEASE SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

- A. Have you ever had angina or a heart attack? Yes No
- B. Date of first symptoms _____
- C. Age at time of angina or heart attack _____
- D. Have you ever had angioplasty surgery? Yes No
Bypass surgery? Yes No
Type of bypass (I.e., single, double, etc.) _____
Date of surgery _____
- E. What medication(s) are you taking? _____

Any medication in the past? Yes No
Dates and details _____

- F. Any known family history of heart disease before age 60?
 Yes No
If yes, give details _____
- G. Do you smoke? Yes No Number per day _____
- H. Any future treatment recommended? _____
- I. Name and address of attending physician _____

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DIABETES QUESTIONNAIRE



Cox Health Systems Insurance Company

- 1) When were you first diagnosed with Diabetes Mellitus? _____ What was your age at first diagnosis? _____
- 2) Are you insulin dependent (IDDM) or non-insulin dependent (NIDDM)? _____
- 3) Please indicate the type and dosage of insulin or oral medication you are currently taking _____
- 4) Do you regularly check or do you regularly have your blood sugar levels checked?
 Yes No If so how often? _____
Please indicate the last three blood sugar level readings and the dates of each.

- 5) To date have you suffered from any complications to any other bodily functions as a result of diabetes? Yes No
If yes please indicate. _____
- 6) In the past 24 months please indicate the dollar amount of medical expenses incurred as a result of diabetes or any complications thereof. _____

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DIGESTIVE QUESTIONNAIRE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. What is the diagnosis of the illness? If ulcer, indicate type: _____
If ulcer, indicate type: Gastric_____ Duodenal_____ Location? _____
2. Indicate the duration of illness and number of attacks:
a) Date illness began: _____
b) Number of attacks: _____
c) Date of last attack: _____
d) Date of recovery: _____
3. What symptoms have appeared during the illness? Vomiting of blood___ Vomiting___
Nausea___ Bloody or black stool___ Loss of weight___ Heartburn___ Constipation___
Diarrhea___ Difficulty in Swallowing___ Jaundice or Yellow Skin___ Pain___ Other (describe) _____

4. How frequently have these symptoms appeared? Recurrent___ Continuous___ Occasional___
Give full details: _____

5. What special examinations have been made? X-Ray___ Fluoroscopic___ GI Series___
Ultrasound___ None___ Other (specify): _____

6. How has the illness been treated? Hospitalization___ (If yes, give date and duration): _____

Surgery_____ (If yes, give name of operation and date): _____

Medicine and diet___(If yes, give full details): _____

6. Have both symptoms and treatment ceased?___ If so, give date of last symptoms and date of last treatment _____

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DRUG QUESTIONNAIRE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. List names of substances/drugs used: _____

2. List the amount, frequency, and length of abuse: _____
3. Date drugs/substances were last used: _____
4. Have you ever participated in a drug/chemical dependency program? _____
Voluntarily or involuntarily? _____
5. Name and location of treatment facility, if known: _____
Name of consulting physician, if known: _____
Inpatient or outpatient program: _____ Length of treatment _____
6. Any relapses/re-use of substances/drugs? _____ If so, explain: _____

7. Any history of psychiatric counseling? _____ When? _____
Frequency and date of last visit: _____
8. Do you belong to a support group? _____ If so, how often do you attend? _____
9. Ever been treated for depression, anxiety disorder or for any self-inflicted injury? _____
If yes, when and explain details: _____

10. Ever been treated for any medical condition attributed to drug abuse? (I.e., heart arrhythmia,
hypertension, seizures, or chronic cough) _____ If yes, when and explain details: _____

11. Ever fail a drug test? _____ If so, when and give details: _____

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DUI SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. What was the date of your DUI? _____
2. Have you had any prior DUI's? Yes No
3. Was your DUI in connection with a moving violation? Yes No
4. Was your DUI in connection with an accident? Yes No

5. Has any treatment for alcohol use, such as psychiatric counseling or state programs, been recommended or received? Yes No
If yes:
 - a) What was the date you were last seen or attended the program? _____
 - b) Was it an inpatient or an outpatient program? _____
 - c) Were any medications taken? Yes No Date last used: _____
List medications: _____

- d) Name of doctor or counselor who treated: _____

6. Have you ever been advised to decrease or stop alcohol consumption? Yes No
If yes, who suggested this? _____

7. When did you last have an alcoholic beverage? _____
8. Type of alcohol and quantity now consumed: _____
9. Driver's license Number: _____

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**ENDOCRINE
THYROID/DIABETES**



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

THYROID:

1. Overactive_____ Underactive_____
2. Date of diagnosis: _____
3. Is there a growth/goiter present? Yes No
History of malignancy: Yes No
4. Controlled with medication? _____
5. Name of current medication and dosage: _____
6. Type and date(s) of treatment _____

7. Ever hospitalized for this condition? ____ If answered yes, reason and dates: _____

8. If surgery was performed, type and date of surgery: _____
9. Type of future anticipated treatment: _____
10. Name and address of doctor _____

DIABETES:

1. Type: _____ Date of diagnosis: _____
2. Height: _____ Weight: _____ Date of Birth: _____
3. Treatment: Diet Controlled _____ Type of Diet _____
Oral Medication _____ Name and dosage _____
How often _____
Insulin _____ Type _____ #units AM _____ PM _____
4. Do you ever go off your diet or stop taking your medication? Yes No
If yes, please explain: _____
5. Have you ever been hospitalized for diabetes: Yes No If answered yes, when? _____
6. How often do you visit your doctor? _____ Date of last visit: _____
7. Doctor's name and address: _____

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SIGNATURE OF PROPOSED INSURED

EPILEPSY/SEIZURE



Cox Health Systems Insurance Company

Proposed Insured Name: _____

Dependent Name (if applicable) _____

Social Security # _____

1. Date of onset: _____

2. Type of seizures (I.e., grand mal, petit mal, psychomotor, etc.) _____

3. Characteristics of seizure (I.e., loss of consciousness) _____

4. Date of last seizure: _____

5. Type and date(s) of treatment _____

6. Name medication(s) currently taken: _____

7. Ever hospitalized for this condition? _____ If so, when: _____

8. Name and address of doctor: _____

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SIGNATURE OF PROPOSED INSURED

EYE DISORDER



Cox Health Systems Insurance Company

Proposed Insured Name: _____

Dependent Name (if applicable) _____

Social Security # _____

1. Medical condition (diagnosis): _____

2. Date of onset _____

3. Type and date(s) of treatment: _____

4. Controlled with medication? _____

5. Name medication(s) currently taking _____

6. Which eye? _____

7. If surgery was performed, type and date of surgery: _____

8. Describe visual impairment, if any: _____

9. Type of future treatment anticipated: _____

10. For cataracts only: if removed from one eye, is the other lens cataract free: _____

11. Name and address of doctor: _____

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SIGNATURE OF PROPOSED INSURED

FEMALE GENITAL DISORDER



Cox Health Systems Insurance Company

Proposed Insured Name: _____

Dependent Name (if applicable) _____

Social Security # _____

1. What is the name of your condition? _____

2. How and when was your condition first discovered? _____

3. Have you ever had any symptoms? Yes No

If yes, please list symptoms ou have experienced: Irregular Periods_____ Abdominal pain_____ Heavy menstrual bleeding_____ Other (please explain) _____

4. Have you ever had any abnormal pap smears:

Yes No If yes, please provide details, including dates and results:

5. Date and results of last pap smear: _____

6. Have you received any testing for this condition? Yes No

Any malignancy found? Yes No If yes, please provide names of tests, dates, and results _____

7. Have you received any treatment for this condition? Yes No

If yes, please provide complete details including names and dosages of medications and date last taken: _____

8. Has surgery ever been performed for this condition? Yes No

If yes, please provide names of surgery, which organs were removed, dates and results:

If no, has surgery ever been suggested or recommended? Yes No

Please provide full details, including your plans for possible surgery: _____

9. Have you ever had any other gynecological symptoms or conditions? Yes No

If yes, please provide dates and details: _____

10. Name and address of doctor: _____

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SIGNATURE OF PROPOSED INSURED

FIBROCYSTIC BREAST DISEASE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. When were you diagnosed as having fibrocystic breast disease? _____
2. Is the fibrocystic breast disease: mild_____ moderate_____ severe_____
3. What tests have been performed? (Please provide names of tests, dates, and results)

4. Have you ever had biopsies or surgery for fibrocystic disease? _____
If yes, please provide details, including dates and results: _____

5. At what frequency has your doctor recommended that you have mammograms? _____

6. When was the last mammogram? _____
7. What was the result of your last mammogram? _____
8. Are there any masses or microcalcifications present? _____
If answered yes, please explain: _____

9. Has any further testing such as sonogram or biopsy been recommended?_____ If answered yes, please explain _____

10. Name and address of doctor _____

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SIGNATURE OF PROPOSED INSURED

HEADACHE/MIGRAINE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Date of diagnosis _____ Date of last headache _____

2. What type of headaches do you suffer from? (Cluster, migraine, or sinus) _____

3. Cause for headaches ever determined? Yes No If yes, please
give details _____

4. How often do you have headaches? _____

5. Are they mild, moderate, or severe? _____

6. Duration of headaches: _____

7. Treatment: _____

8. Any special tests? Yes No If answered yes, please give details:

9. Have you ever been disabled due to headaches? Yes No
If yes, please give details: _____

10. Name and address of physician: _____

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HEART DISORDERS



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Have you ever been diagnosed as having or been treated for any form of heart disease?
 Yes No
2. Did you have a heart attack? Yes No
3. Surgery performed: _____Angioplasty Date____/____/____
_____Bypass Date____/____/____ How many arteries_____
_____Other Date____/____/____ Describe_____
4. Since your surgery and/or heart attack have you experienced any of the following:
____Chest Pain ____Shortness of breath ____Palpitations or irregular heart beats
5. When is the last time you saw your doctor for your heart condition? _____
Were you having any symptoms or problems which prompted this visit ____yes____no
If yes please give full details _____
6. Please list your current medications _____
7. Approximate dates and results of your last:
 - a. Physical Exam Date_____ Results _____
 - b. EKG Date_____ Results _____
 - c. Echo Date_____ Results _____
 - d. Treadmill Date_____ Results _____
8. If you have not had any of the above tests, has your doctor recommended that you do?
____yes ____no
9. Has your doctor recommended or suggested that any additional treatments are necessary? ____yes____no. If yes please give details _____
10. Do you have any restriction or limitations on either diet or physical activities
____yes____no. If yes please explain.

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HEPATITIS SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

A. Date on onset _____ Duration _____

B. What type of hepatitis were you diagnosed with?
 A B C Unknown Other _____

C. Type and date(s) of treatment _____

D. Name(s) of medication(s) currently taking _____

E. Any current symptoms? _____ Abnormal liver tests? _____
Date of abnormal test(s) _____

F. Date of follow-up blood work _____

G. Degree of recovery _____

H. Name and address of physician consulted _____

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HIGH BLOOD PRESSURE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Age at onset _____ When did treatment begin? _____
2. Name and dosage of current medication: _____
3. Has there been a change in medication in the past year? YES ___ NO ___ If answered
yes, list **name** of medication, **dates**, and **dosage** prescribed and **reason** of change:

4. How many doctor's visits per year for blood pressure? _____
5. Have you ever been told by your doctor that your blood pressure was difficult to control?

6. A) When was your most recent blood pressure check? _____

B) Provide at least three of your blood pressure readings. One reading from the most recent
office visit and one from the past year (could be the same reading):

READING - DATE	READING - DATE
1. _____	3. _____
2. _____	4. _____

7. What has been your highest reading in the past? _____ Date _____

8. Have you ever had an EKG? YES ___ NO ___ If answered yes, Date _____
Results _____

9. Have you ever had a treadmill test? YES ___ NO ___ If answered yes, date _____
Results _____

10. Do you smoke? YES ___ NO ___ If answered yes, number of packs per day _____

11. Have you ever been treated for any of the following:

*Irregular heart beat	YES ___ NO ___	*Severe headaches	YES ___ NO ___
*Chest pain	YES ___ NO ___	*Dizziness	YES ___ NO ___
*Shortness of breath	YES ___ NO ___	*Numbness or tingling	YES ___ NO ___
*Loss of consciousness	YES ___ NO ___	in the hands/face	YES ___ NO ___

Details and Treatment _____

12. Doctor's name and address: _____

APPLICANT STATEMENT:

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and they shall form a part of any policy of insurance which is issued.

DATE: _____

SIGNATURE OF PROPOSED INSURED

HIGH CHOLESTEROL



Cox Health Systems Insurance Company

Proposed Insured Name: _____

Dependent Name (if applicable) _____

Social Security # _____

1. Date you were diagnosed with elevated cholesterol? _____

2. What medication(s) are you currently taking, dosages, how many times a day?

3. Has there been a change in medication in the past year? YES ___ NO ___ If answered yes, list **name** of medication, **dates**, and **dosage** prescribed and **reason** of change:

4. Please provide your most recent readings for the following:

	(Reading)	(Date of reading)
HDL / Cholesterol ratio:	_____	_____
HDL Reading:	_____	_____
Cholesterol Reading:	_____	_____

5. Do you have any history of artery disease, heart attacks, or strokes? If yes, please explain:

6. Is there any family history of artery disease, heart attacks, or strokes? If yes, please explain:

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SIGNATURE OF PROPOSED INSURED

INJURIES QUESTIONNAIRE



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. When did the injury take place? _____

2. What was the cause (e.g. injured by accident, shot, stab)? _____

3. How long unconscious? _____

4. How did the doctor define the injury (e.g., concussion of the brain, fracture of skull or other bones, rupture of internal organs, head shot, stab of the lung)?

5. What kind of treatment have you received (medical and /or surgical)? Give full particulars and dates. _____

6. Present state:
a. If fully recovered, since when? _____
b. If not fully recovered, state symptoms and give full particulars. _____

c. Are there any sequels due to the injury? If so, give full particulars. YES NO

d. Is an operation contemplated? YES NO

7. Please give full name and address of your attending physician.

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JOINT/ARTHRITIS



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Which Joint(s) ? _____ Circle One LEFT RIGHT
2. What was the exact medical diagnosis for this condition? _____
 a) If arthritis, type (osteo, rheumatoid, etc...): _____
3. What was the cause of the medical condition? _____

4. Provide names, dates and results of all diagnostic tests: _____

5. Please give dates and details of treatment, recommendations, or surgery: _____

6. Names, strengths and dosages of all medications prescribed: _____

7. Any deformity or loss of movement: _____

8. Are you currently receiving any type of treatment? If so, how frequently: _____

9. Has surgery ever been suggested, recommended, or contemplated? _____

10. Still scheduled for follow-up care or visits? _____

11. Please describe any complications or remaining problems: _____

12. Name and address of doctor: _____

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SIGNATURE OF PROPOSED INSURED

KIDNEY/BLADDER/PROSTATE
(Infection, Stone, Tumor, Obstruction)



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. Date of onset _____ Number of attacks per year _____
Date of last attack _____
2. Type and date(s) of treatment _____
3. Name of medications currently taken _____
4. Is medication taken: on a continuous basis _____ as needed _____? How often is it needed? _____
5. Type and date of surgery, if any _____
6. Any current symptoms (I.e. infections, tumor, obstruction)? _____
7. Degree of recovery _____
8. For kidney infections: type (I.e. pyelonephritis, glomerulonephritis) obtain from doctor:

9. For kidney stones: one or both sides? _____
Any recurrent episodes? _____
10. Name and address of physician consulted for this condition _____

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MENTAL/EMOTIONAL DISORDERS



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

1. What was the exact diagnosis? Read each and circle those that apply: a) Anxiety
b) Behavioral Disorder c) Major Depression d) Hyperactivity e) Attention Deficit Disorder
f) Pyschotic Disorder g) Other (explain) _____
2. Please state your symptoms from the following and circle those that apply: a) Depression
b) Paranoia c) Hysteria d) Suicidal thoughts e) Mood changes f) Abuse of alcohol/drugs
g) Other (explain) _____
3. How frequently have these symptoms occurred? Circle One: a) Recurrent b) Continuous
c) Occasionally
4. Were there any physical symptoms, such as diarrhea, vomiting, palpitations, shortness of
breath, anorexia, pain? If so circle and explain: _____

5. What was the date of first treatment? _____
6. What type of treatment has been received? Circle those which apply: a) Medication
b) Hospitalization c) Counseling d) Other (explain) _____

Please provide dates and details of treatment. If counseled, how frequently:

Names and dosages of medications, dates of hospitalization:

7. Did this condition prevent you from performing your normal duties? _____ If so, date of
disability _____
8. Date of most recent treatment: _____
9. is treatment still continuing? ____ If so, how frequently? _____
10. How long has it been since symptoms last occurred? _____
11. If not hospitalized, has hospitalization ever been suggested or recommended? _____ If so,
when and why?

12. name and address of doctor or counselor: _____

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PREGNANCY SUPPLEMENT



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

A. Pregnancy due date _____

B. Results of amniocentesis or ultrasound _____

C. Explain an family history of hereditary/chromosomal disorders or history of previous newborns who experience birth defects, previous blood transfusions, R.H. Negative Sensitization or other problems. _____

D. Explain an history of miscarriage, therapeutic abortion, stillbirth, premature birth, cesarean section delivery, or other complications of pregnancy _____

E. Explain any difficulty, including vaginal bleeding, development of diabetes or hypertension, with this pregnancy _____

F. Do you smoke? YES NO Number per day _____

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SPORTS OR HOBBIES



Cox Health Systems Insurance Company

Proposed Insured Name: _____
Dependent Name (if applicable) _____
Social Security # _____

I. Auto or motorcycle racing:

- 1a. Type of auto racing: champion____
drag____ sportscar____ stockcar____
other _____
- 1b. Type of motorcycle racing: champion ____
hill climbing____ scrambles____
other _____
- 2. Type of course: dragstrip ____
road____ track____ oval____
other _____
- 3. Number of races in last 12 months: _____
- 4. Maximum speed reached: _____
- 5. How long have you been participating?

II. Rodeo Competition:

- 1. Type of events: _____

- 2. How often in the last 12 months? _____
in next 12 months _____
- 3. Participation is local only____ national_____

III. Underwater Diving:

- 1. Type of diving: hardhat____
scuba____ skin____
other _____
- 2. Number of dives in last 12 mos.____
Number anticipated in next 12 mos.

- 3. Usual depth of dives _____
Maximum depth _____
- 4. How long have you participated?

- 5. Do you dive commercially or
intended to do so?
YES____ NO____
- 6. Do you hold a certification?
YES____ NO____

IV. Sky diving or parachuting:

- 1. Type of jumps made: _____
- 2. Total number of jumps _____
- 3. How long have you been
participating? _____
- 4. Number of jumps in last 12 months

Number anticipated in next 12
months? _____
- 5. Are you a member of an
association or club?
YES____ NO____

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