health plan
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MDA Health Plan Questionnaire

This health questionnaire is used to develop a proposal for coverage in the MDA Health Plan. Each employee who desires coverage must complete this form. The information you provide is kept strictly confidential and is used by MDA Insurance only for the purposes of eligibility and rating. This information is not shared with your employer unless you choose to do so.

- **Provide information about your spouse and dependents**. If you need additional space, attach a separate sheet. Be sure to sign and date all additional pages.
- **Please complete the health questionnaire clearly and in full** or it will be returned to you, resulting in a delay in processing. Incomplete questionnaires may delay the effective date of your coverage.
- **Read carefully and sign the enclosed authorization**.
- For HIPAA purposes, all forms must be submitted via fax to MDA Insurance at 517.484.5460 or via email to Tina Voss at *tvoss@mdaifg.com*. **Please do not return this form to your employer.**

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STEP 1 Employee information

Employee name (last, first, initial)	Office identifier *(MDA office use only)*	Employer name		
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight	Phone number
Home address	City	State	Zip code	

STEP 2 Dependent information

(your spouse and/or each eligible child you wish to enroll)

Spouse

Dependent name (last, first, initial)			
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight

Dependent 1

Dependent name (last, first, initial)			
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight

Dependent 2

Dependent name (last, first, initial)			
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight

Dependent 3

Dependent name (last, first, initial)			
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight

Dependent 4

Dependent name (last, first, initial)			
DOB (month/day/year)	Gender ☐ Male ☐ Female	Height	Weight

STEP 3 Health information

Check all that apply in the past 5 years to **anyone** named on this application.

1. ☐ Abnormal heart rate or rhythm
2. ☐ Arthritis
3. ☐ Asthma or chronic obstructive pulmonary disease
4. ☐ Autoimmune disease or disorder (for example: Crohn's disease, ulcerative colitis, interstitial cystitis, lupus erythematosus, Sjogren's syndrome)
5. ☐ Back or spine disease or injury
6. ☐ Birth defect or birth injury
7. ☐ Brain abnormality, disease or injury
8. ☐ Cancer (other than basal cell skin cancer) or leukemia
9. ☐ Complications of surgical procedure or of other medical care
10. ☐ Cystic Fibrosis, hemophilia, Down syndrome or other genetic disorder
11. ☐ Depression, anxiety, bipolar illness, or any other mental disorder
12. ☐ Diabetes
13. ☐ HIV infection or AIDS
14. ☐ Heart or circulatory disease or disorder
15. ☐ Hospital admittance as an inpatient
16. ☐ Implant, transplant, graft or joint replacement
17. ☐ Kidney disease
18. ☐ Liver disease
19. ☐ Septicemia
20. ☐ Stroke

Please give details about any checked answers below.

Please provide details to any checked answers in the following section. Please include full details including person, condition, treatment, prescription drugs, hospitalization, dates, and current condition. If additional space is needed, please continue on another page (sign and date that page).

Question #	Applicant name	Condition	Date diagnosed	Date last treated	Treatment, including medication names with dosage and frequency

Employee initials _____

STEP 4 Other information

1. ☐ Yes ☐ No Have you or any person applying for coverage ever been declined, postponed or had conditions excluded or charged an additional premium for any health, life or disability insurance coverage? If "yes", please provide details: name, when and why:

2. ☐ Yes ☐ No In the past 5 years, has anyone applying for coverage been disabled, hospitalized, confined or unable to work due to a medical condition? If yes, please provide details:

MDA Health Plan requires proper handling of individually identifiable health information for applicants and members, and details of confidentiality policies and procedures are available upon written request to MDA Health Plan. I understand that the following parties may need to provide or collect information on me or my dependent applicants in regard to this questionnaire: MDA Health Plan, Priority Health and its reinsurers and authorized Business Associates. I authorize the entities having information about me or any of my dependents to provide such information as requested to MDA Health Plan, Priority Health or its Business Associates or Agents as may be required for rating purposes. Unless revoked earlier, this authorization will be valid for a period of thirty (30) days after the date it is signed, and a photocopy of this authorization is as valid as the original. I understand that I can revoke this authorization at any time by giving written notice to MDA Health Plan at 3657 Okemos Road, Suite 100, Okemos, MI 48864. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I understand that authorizing the disclosure of this health information is voluntary and will be used for self-funded group underwriting purposes. I understand that the persons to whom information is disclosed under this authorization may possibly re-disclose the information in which case it may no longer be protected by federal rules governing privacy and confidentiality. I have read the contents of this authorization and understand and agree to the use and disclosure of my information as specified. I declare that the answers and information presented on this application are complete and true for all applicants to the best of my knowledge and belief. I agree that the MDA Health Plan may cancel this coverage for any ineligible family member or one on whom erroneous or false information has been submitted. I understand that I am personally assuming liability for reimbursement to the MDA Health Plan for any benefit payment made on behalf of any such member. This is not an application for coverage.

Employee signature	Date