aetna℠

Florida
Group Medical Questionnaire

This form is to be completed by the Employer/Owner or Authorized Company Officer, except as follows:
Group size 10 to 50: Individual Health Questionnaires must be completed when the group is requesting Life coverage above the Guarantee Issue level.
Group size 51 to 100: Individual Health Questionnaires must be completed when the group is a virgin group; is a newly formed business; or is requesting Life coverage above the Guarantee Issue level.
NOTE: Medical claims may be reviewed for any individuals who had prior Aetna coverage.

Group Name	
To the best of your knowledge, answer the following questions for all enrollees including yourself, along with Partners, Officers, COBRA or State Continuees and their dependents to be covered under this plan.	
1. How many employees enrolling for coverage have missed more than 10 consecutive days of work due to illness or injury in the past 12 months?	
2. Are any employees, dependents or COBRA continuees considered disabled?	☐ Yes ☐ No
3. How many employees enrolling for coverage have received Workers' Compensation, Social Security Income or Medicare in the past year?	
4. How many employees enrolling for coverage have received Disability Income in the past year?	
5. Has anyone had claims more than $10,000 in the last 12 months?	☐ Yes ☐ No
6. Has the Group or Broker/Agent requested and/or received paid claim information within the past 6 months from your current carrier? If "Yes," provide all claim information received.	☐ Yes ☐ No
7. How many enrollees are currently pregnant? C section planned ☐ Yes ☐ No Multiples Expected (# _____) Complications ☐ Present ☐ Past	
8. Is any enrollee a transplant recipient or candidate?	☐ Yes ☐ No
9. Has your business been insured with Aetna? If Yes, provide group number: _____	☐ Yes ☐ No
In the past 3 years has any enrollee been:	
10. Hospitalized or had a surgical procedure?	☐ Yes ☐ No
11. Advised to have tests, surgery, hospitalization or is treatment needed or pending?	☐ Yes ☐ No
In the past 3 years has any enrollee been diagnosed or treated for any of the following (check all that apply):	☐ Yes ☐ No

12.
- ☐ AIDS/ARC/HIV+
- ☐ Anxiety/Stress/Depression
- ☐ Arthritis
- ☐ Asthma/Emphysema/COPD
- ☐ Back/Spine/Neck
- ☐ Bipolar
- ☐ Birth Defect/Congenital Abnormality
- ☐ Blood Disorder/Hemophilia
- ☐ Bones/Joints/Muscles
- ☐ Brain
- ☐ Cancer (Type: _____)
  - ☐ Surgery ☐ Chemo ☐ Radiation
- ☐ Cardiovascular
- ☐ Carpal Tunnel
- ☐ Central Nervous Disorder
- ☐ Cerebral Palsy
- ☐ Circulatory Disorder
- ☐ Chronic Fatigue
- ☐ Cleft Palate
- ☐ Colitis
- ☐ Connective Tissue Disorder
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Ears/Eyes/Throat
- ☐ Eating Disorders
- ☐ Emphysema/Pulmonary
- ☐ Endocrine/Metabolic
- ☐ Epilepsy/Seizures
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Growth Disorder
- ☐ Heart Attack/Chest Pain
- ☐ Heart Disorder/Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol/Triglycerides
- ☐ Immune Disorder
- ☐ Infertility
- ☐ Intestine
- ☐ Joint Replacement
- ☐ Kidney/Bladder/Urinary
- ☐ Liver/Spleen/Pancreas
- ☐ Lungs/Respiratory
- ☐ Lupus
- ☐ Mental/Emotional/Nervous
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscular Condition
- ☐ Neurological
- ☐ Nervous System
- ☐ Pacemaker
- ☐ Pancreas
- ☐ Paralysis
- ☐ Pituitary/Adrenal
- ☐ Pneumonia
- ☐ Reproductive System
- ☐ Sickle Cell Anemia
- ☐ Skin Disorder
- ☐ Stomach/Esophagus/Digestion
- ☐ Stroke
- ☐ Substance Abuse (alcohol or drug)
- ☐ Thyroid
- ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
- ☐ Tumor
- ☐ Venereal
- ☐ Other _____

Provide details to any "Yes" answers above. Use additional paper if necessary.

EE or Dep	Age	Condition	Treatment	$ Amount of Claims	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)	Names of Medications	Current Status

I, as an Officer of this Company named above, who is responsible for the Company's benefit plan, certify to the best of my knowledge the information I have furnished is complete and accurate and includes all enrollees and dependents applying for coverage. I understand material misrepresentations or willful omissions may result in cancellation of insurance, non-renewal of coverage or a change in premium. If errors or omissions are subsequently found, Aetna Inc. reserves the right to revise rates or rescind the quote.

Employer/Owner/Officer Signature	Print Name	Title	Date (MM/DD/YYYY)

NOTE: This form must be completed and signed by the employer, owner or officer of the company and is subject to review and approval by Aetna Underwriting.

Print Broker Name	Broker Signature	Date (MM/DD/YYYY)