

# Northwest Employer Trust Group Medical Questionnaire

Employer's Name	Customer Number	Industry/SIC:
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**Medical Profile**

Employer: Please answer the following questions to the best of your knowledge for all eligible employees and their dependents (proprietors, partners, corporate officers, employees, spouses and dependent children). Give details to questions answered "Yes" in the space provided.

A. Have any claims greater than \$5,000 been paid in the last 12 months?  Yes  No

B. During the next 12 months are there any employees or dependents that are expected to be hospitalized or treated for a serious medical condition?  Yes  No If "Yes" check the appropriate box(es) below.

<input type="checkbox"/> AIDS/Immune Disorders	<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Infertility	<input type="checkbox"/> Neurological
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Intestines	<input type="checkbox"/> Pancreas
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Drug/Substance Abuse	<input type="checkbox"/> Kidney	<input type="checkbox"/> Skin
<input type="checkbox"/> Back, Neck	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver	<input type="checkbox"/> Stomach
<input type="checkbox"/> Blood	<input type="checkbox"/> Ears/Eyes	<input type="checkbox"/> Lungs	<input type="checkbox"/> Stroke/Paralysis
<input type="checkbox"/> Bone/Join	<input type="checkbox"/> Emphysema/Pulmonary	<input type="checkbox"/> Lupus	<input type="checkbox"/> Venereal
<input type="checkbox"/> Brain	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental/Nervous	<input type="checkbox"/> Other, Detail below
<input type="checkbox"/> Cancer/Tumor	<input type="checkbox"/> High Risk Pregnancies	<input type="checkbox"/> Migraines	

C. Has any employee or dependent been declined or adjusted for group life under your present or prior group plan?  Yes  No

D. Are there any employees that are currently out on disability?  Yes  No How many? \_\_\_\_\_  
Over the next 12 months, are you aware of any potential disability claims?  Yes  No How many? \_\_\_\_\_

E. Are any employees or dependents pregnant?  Yes  No How many? \_\_\_\_\_

If you answered "Yes" please provide the following information for each individual with a likely serious continuing condition. Use additional sheet if necessary.

EE or Dep.	Age	Site Location	Nature of Condition	Dates of Treatment	Name of Medication	\$ Amount of Prior Claims	Prognosis / Current Treatment

The Prospective Applicant hereby certifies that the information on this form is complete and true to the best of his/her knowledge. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Prospective Applicant Name and Title (please print)	Prospective Applicant Signature	Date
Broker Signature	Date	