



**MEDICAL CONDITIONS** (Please check the appropriate boxes below)

	Member/Self	Spouse	Dependent 1	Dependent 2	Dependent 3	Dependent 4
Allergies: hay fever, etc.						
Arthritis						
Asthma						
Chronic Bronchitis (COPD)						
Depressions						
Diabetes						
Enlarged Prostrate/BPH						
Gastric Reflux/GERD						
Glaucoma						
Heart Attack or Angina						
Heart Failure/Weak Heart						
High Blood Pressure						
High Cholesterol						
Inflammatory Bowel Disease						
Migraine Headaches						
Osteoporosis						
Seizures						
Stroke						
Thyroid Disease						
Trouble With Blood						
Ulcers (Peptic, stomach, etc.)						
Vascular Disease						
Other						

**ADDITIONAL COMMENTS**

---



---



---



---



---



---



---



---

**Print Name**

**Signature**

**Date**

*Thank you for completing this questionnaire. Data may be utilized in accordance with existing law by your plan administrator, sponsor, employer, and/or their agents in connection with the benefit plan program. Your information is protected and confidential. It is not provided to any outside sources other than those mentioned above, for any reason, without your prior written consent.*