

# **Benefits Client Questionnaire**

Exact Name of Company:

Address of Company:

Telephone #

Fax #

Are there any other locations to be included?

Are there any employees out of state? If so, please note on census.

Current Carrier(s) for benefits:

(Please attach a copy of most current billing statement and plan design)

Employer contribution towards employee cost:

Employer contribution towards dependent cost:

Renewal or Requested Effective Date:

Type of coverage requested (i.e.: medical, dental, disability):

Preferred Plans (i.e.: HMO, POS, PPO):

Are there any ongoing or chronic health conditions that you are aware of?

If so, please list diagnosis, date diagnosed, current treatment including medications and recent hospitalizations and prognosis.

Are there any other special requests?

Please complete attached census.

**Return All Paperwork To:**

Johnson & Bryan  
1575 Northside Drive  
Bldg 100, Suite 100  
Atlanta, GA 30318  
Attn: Benefits Dept.



## CONFIDENTIAL EVIDENCE OF HEALTH STATUS

A. Indicate your mother's maiden name: \_\_\_\_\_

B. Indicate the following for your self and any dependents you plan to insure:

|          | Date of Birth | Sex (circle one) | Height   | Weight |
|----------|---------------|------------------|----------|--------|
| Employee |               | F / M            | FT    IN | LBS    |
| Spouse   |               | F / M            | FT    IN | LBS    |
| Child #1 |               | F / M            | FT    IN | LBS    |
| Child #2 |               | F / M            | FT    IN | LBS    |
| Child #3 |               | F / M            | FT    IN | LBS    |
| Child #4 |               | F / M            | FT    IN | LBS    |

C. This section must be completed for the employee and any dependents to be covered. Do not leave any questions unanswered.

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| D. Are you or any dependent currently under any treatment of prescribed medications?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 1. Have you or any dependent had unexplained weight loss or fatigue in the past 12 months?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you or any dependent ever had, been diagnosed with, counseled, consulted, or treated for any of the following: (please circle disease or disorder)  |                          |                          |
| A. Chest pain; disease of heart, arteries or blood vessels; high or low blood pressure?   | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Nervous, mental or emotional disorder; convulsions; epilepsy; unconsciousness?   | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Asthma or other disease of lungs or respiratory organs?  | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Kidney stones; disease of the kidney, bladder, male or female organs; or infertility?  | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Cancer, and/or cancerous tumor? (state type; part of body)   | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Diabetes; liver or thyroid disease; or enlargement of the lymph nodes?   | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Stomach, gall bladder, intestinal or colon disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Rheumatoid arthritis or back disorders?  | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Phlebitis, paralysis, or any other physical impairment or deformity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Alcoholism or drug habit, or been a member of Alcoholics Anonymous?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you or any dependent been diagnosed or received treatment for AIDS or an AIDS-related complex or other immune system disorder within the past 5 years?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you or any dependent been hospitalized or had hospitalization advised, had surgery or been advised to have surgery, had any injury, illness, medical attention or medical advice or treatment during the past 5 years for any reason not already mentioned? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you or any dependent pregnant or ever had a cesarean section?  | <input type="checkbox"/> | <input type="checkbox"/> |

Please give details to "yes" answers from questions 1-6 above (specify question number).

| Question # | Person Treated (Employee, Spouse, Child) | Illness or Impairment & Medications (If Any) | Dates Treated |
|------------|--|--|---------------|
|            |  |  |               |
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|            |  |  |               |