



Health Net

Individual Health Risk Questionnaire (HRQ)

Instructions: The questions below apply to each employee and dependents that are applying for coverage listed on this application. They apply to both past and present conditions or symptoms. Answer each question truthfully and completely. Attach a piece of paper if you need more space. Complete every item even if the answer is "no." We consider the answer to each question to be material to the risk Health Net assumes in extending health care coverage. Applications will be returned if all questions are not answered completely.

Please fill in: Company Name \_\_\_\_\_

Table with 10 columns: First Name, Last Name, Sex M/F, DOB, Height, Weight, Tobacco Use Within Last 12 Months Y/N, Name of Primary Physician, Physician's Phone Number. Rows for Employee, Spouse, Children.

Please check any condition, treatment or care mentioned below that applies. All questions must be answered. For [X] Yes, please provide detail in section 5. 1) Indicate if you or any listed dependents have ever suffered from, or received care, counseling or been advised for any of the following:

- Alcohol/Drug use or abuse [ ] Yes [ ] No
AIDS/HIV or ARC [ ] Yes [ ] No
Back or Spine disorder [ ] Yes [ ] No
Cancer or Tumor [ ] Yes [ ] No
Diabetes [ ] Yes [ ] No
Digestive/Bowel disorder [ ] Yes [ ] No
Heart Condition [ ] Yes [ ] No
Immune system disorder [ ] Yes [ ] No
Kidney/Renal disorder [ ] Yes [ ] No
Liver disorder [ ] Yes [ ] No
Ulcer [ ] Yes [ ] No
Hypertension [ ] Yes [ ] No
Mental disorder [ ] Yes [ ] No
Neurological disorder [ ] Yes [ ] No
Paralysis/Stroke [ ] Yes [ ] No
Respiratory/Lung disorder [ ] Yes [ ] No
High Blood Pressure [ ] Yes [ ] No
Last Reading (systolic/diastolic) \_\_\_\_\_

2) Is female applicant, spouse or any dependent now pregnant? [ ] Yes [ ] No Due date: \_\_\_\_\_

If yes, name and relationship

Are complications anticipated? [ ] Yes [ ] No Multiple birth? [ ] Yes [ ] No

Prior history of miscarriage, therapeutic abortions, stillbirth, cesarean section or other complication of pregnancy? [ ] Yes [ ] No

Any congenital anomalies or health complications with previous newborns? [ ] Yes [ ] No.

Any congenital anomalies or health complications with current fetus? [ ] Yes [ ] No.

Any problems, including vaginal bleeding, with pregnancy? [ ] Yes [ ] No

3) Have any applicant(s) been counseled or advised that they have or may have any disease, disorder, impairment, deformity, injury, or any chronic or untreatable condition whether active or in remission? [ ] Yes [ ] No

4) Have any applicant(s) had medical or surgical consultation, advice, or treatment (including medication) for any condition(s) during the past 36 months? [ ] Yes [ ] No

5) If you have checked [X] Yes, for any item in sections 1-4, please explain below (use additional sheet of paper if necessary)

Table with 7 columns: Patient's Name, Diagnosis/Condition Requiring Treatment, Treatment, Physician, Physician's Phone Number, Date of Illness (mo/yr), Was recovery complete? Rows for patient details.

6) Have you or any listed dependents taken or used any medication or drug within the past 12 months? [ ] Yes [ ] No

If yes, please explain below. (Use extra sheet of paper if necessary.)

Table with 4 columns: Patient's Name, Medication Name, Condition Requiring Medication, Still Taking? Y / N. Rows for medication details.

7) Has the applicant or any listed dependent ever been denied insurance coverage? [ ] Yes [ ] No If yes, explain:

8) Do you and your dependents currently have comprehensive coverage under another health plan? [ ] Yes [ ] No

I hereby declare that the foregoing is true and correct. This declaration is made under the penalty of perjury of the laws of the State of Washington. I understand that any false or misrepresented information or statements may result in retroactive termination of coverage.

Employee Name (please print) Signature Daytime Phone # Date

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