Employee Supportive Information Form for Group Health

Please return to: grhealthinfo@thecraigagency.com

EMPLOYER INFORMATION	
Company Name/DBA:	Zip Code of your work location::

TO BE COMPLETED BY EMPLOYEE

A - EMPLOYEE (Primary Applicant)

Name:	(Last) (If you elect to)	(First)	(MI)

Personal Information	Gender: ☐ M ☐ F	Birth Date (mm/dd/yyyy):	**Average number of hours worked per week?**	**Date employed Full-Time: (mm/dd/yyyy)**
Home Location Residing		City	State	Zip

Status: ☐ Single ☐ Married Employee Status: ☐ W2 ☐ 1099 ☐ Owner/Partner	Check One: ☐ Full-Time ☐ Part-Time ☐ Retiree ☐ COBRA ☐ Cal-COBRA COBRA effective date(mm/dd/yyyy)	Earnings Basis: ☐ Salaried ☐ Hourly ☐ Commission

Today's Date	Full time Employment Date:
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PERSONS Considering Group Coverage with their employer
(Include yourself and all family members to be insured for any and all coverages. If more space is needed, attach an additional sheet

☐ Employee Only	☐ Employee Spouse	☐ Employee Child(ren)	☐ Family: Employee, Spouse, & Child(ren)

Include yourself and any family members		**Relationship & Gender**	**Date of Birth (MM/DD/YYYY)**	**Social Security Number**	**Medical election (check if enrolling)**	**Tobacco Use**
		Employee ☐ M ☐ F	XXXXXX	XXXXXXXXX	☐ Medical	☐ Yes ☐ No
		Spouse ☐ M ☐ F			☐ Medical	☐ Yes ☐ No
		Child ☐ M ☐ F			☐ Medical	
		Child ☐ M ☐ F				
		Child				

		□ M ☐ F				
		Child □ M ☐ F				
		Child □ M ☐ F				

ADDITIONAL INSURANCE COVERAGE INFORMATION	
1. Will any current medical plan remain active if coverage is approved?	□ Yes ☐ No
a) If "Yes", for whom?	
2. Are you, your spouse or any dependent children currently covered under Medicare Part A, B, or D?	□ Yes ☐ No
a) If "Yes", for whom?	
b) If yes, will coverage remain active if the coverage for which you are applying is approved?	□ Yes ☐ No

MEDICAL HISTORY

Only include information on those individuals considering coverage

	Height	Weight
Employee		
Spouse		

Do you have children attending college in another state under age 26, that would be covered?	NO	YES
If YES- List the state and next the zip code where they reside.		

Complete all questions below and check all that apply in Question 1.

1. Have you or any of your dependents included on this enrollment form within the past *5 years* received treatment, testing, consulted with or received a diagnosis from a physician or provider for any of the following?.....☐ Yes ☐ No

□ AIDS or HIV
□ Alcohol or Drug Use, Abuse, or Dependency
□ Arthritis or other Skeletal Disorder
  □ Osteoarthritis ☐ Rheumatoid
  □ Other
□ Back Disorders
  □ Chiro ☐ Sprain/strain
  □ Surgery ☐ Other
□ Blood Disorders (including anemia)
□ Cancer or Tumor; Stage
  □ Local (confined to the organ where it began) □ Regional (spread to nearby lymph nodes/organs) □ Distant/Metastasis (spread to distant organs) □ Chest Pain
□ Diabetes Mellitus Date of onset / / □
  Pre-Diabetes ☐ Diet Controlled
  □ Type I ☐ Type II
  □ Insulin Dependent ☐ Insulin Pump
□ Diabetic Related Disorders
  □ Heart disease ☐ Nephropathy
  □ Neuropathy ☐ Peripheral Vascular Disease □ Retinopathy ☐ Stroke
□ Digestive Disorders
  □ Crohn's Disease ☐ Ulcerative Colitis
  □ Other
□ Ear/Eye/Nose/Throat Disorders
□ Endocrine Disorders
□ Fracture/Broken Bone
□ Heart Disorders
  □ Angioplasty ☐ Bypass
  □ Heart Attack ☐ Other
□ High Cholesterol
□ High Blood Pressure
□ Hodgkin's/Lymphoma/Leukemia
□ Immune Disorders
  □ Infertility

Employer Group _____
Name: _____
Today's Date: _____

- □ Kidney Disorders
- □ Knee Injury or Disorder
- □ Liver Disorder/Hepatitis
  - □ Hepatitis B ☐ Hepatitis C
  - □ Hepatitis D ☐ Other
- □ Lupus
  - □ Discoid
  - □ Systemic Lupus Erythematosus

- □ Mental, Nervous or Behavioral Disorder □ Inpatient Treatment ☐ Outpatient Treatment □ ADHD/ADD ☐ Anxiety
  - □ Bipolar disorder ☐ Depression
  - □ Other
- □ Migraine or Chronic Headache
- □ Multiple Sclerosis (MS)
- □ Muscle Disorders
- □ Nervous System Disorders
- □ Paralysis
- □ Partial or Total Disability
- □ Physical Disorder or Deformity
- □ Reproductive Disorders

- □ Respiratory/Lung Disorders
  - □ Asthma ☐ Chronic Bronchitis □ COPD ☐ Other
- □ Seizures
- □ Sexually Transmitted Disease
- □ Stroke or Transient Ischemic Attack
- □ Thyroid Disorder
  - □ Hyperthyroidism ☐ Hypothyroidism □ Growth Disorder ☐ Other
- □ Transplant
  - □ Solid Organ ☐ Blood or Marrow □ Urinary Disorders
- □ Vascular Disorders

2. In the last 5 years, have you or any of your dependents included on this enrollment form:
   a. Been diagnosed with or treated for any condition(s) not identified above? ..... ☐ Yes ☐ No
   b. Been advised of the necessity or possibility of any future hospitalization, treatment, testing or surgery?... ☐ Yes ☐ No

3. Are you or any of your dependents included on this enrollment form currently pregnant? ..... ☐ Yes ☐ No
   a. If yes, Indicate due date / /
   b. Is a Cesarean Section anticipated?..... ☐ Yes ☐ No c. Are multiple births expected?..... ☐ Yes ☐ No d. Are you/your dependent experiencing or anticipating any other complications?..... ☐ Yes ☐ No

4. Have medications been prescribed in the past 18 months for you and/or any dependents included on this enrollment form. (Include pills, creams, injections, liquids, inhalers, pumps, etc.) ..... ☐ Yes ☐ No

Supportive information related to QUESTION 1.

Question	Person	Condition/Diagnosis	Dates Treated	Treatment including Medications and Dosage	Date Last Taken	Prognosis

Your employer has requested a group health quote from TCA. This information is maintained and used under the HIPPA umbrella protecting individuals privacy. Pre-existing health conditions have no effect on obtaining coverage or a group being offered coverage. Rates are offered by tier. (Four categories Single-Partner/Parent & Child & Family) The information provided assists us to build a unique health plan for individual groups with less than 50 employees and any discounts that may be available.

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