**FIRSTCAROLINACARE INSURANCE COMPANY**
**EMPLOYEE HEALTH QUESTIONNAIRE (GROUPS 15 OR MORE EMPLOYEES ONLY)**

The confidential information provided on this form will be used to determine appropriate premium rates for the applicable employer group. You cannot be declined for coverage based on the information provided on this form, and you will not be individually charged a higher premium based on your responses. *No information on this form will be disclosed to your employer. Separate forms must be completed by the employee **and** by the spouse if enrolling in FirstCarolinaCare Insurance Company.*

**Employer Name:** _____

**Employee OR Covered Spouse Name:**_____

1. Please provide the following information for the person named above:

Sex: □ Male □ Female Date of Birth: ___/___/___

Height: _____ Weight: _____

Do you use tobacco products? □ Yes □ No

2. Have you been diagnosed with or currently being treated for any of the following conditions? Please check Yes or No and list any treatments received and approximate dates.

| Condition | | Treatment/Dates | Condition | | Treatment/Dates |
|---|---|---|---|---|---|
| Back or spinal disorders | □ Yes □ No | | Multiple sclerosis | □ Yes □ No | |
| Paralysis | □ Yes □ No | | Stomach/ bowel disorder | □ Yes □ No | |
| Stroke | □ Yes □ No | | Crohn's disease | □ Yes □ No | |
| Cerebral palsy | □ Yes □ No | | High blood pressure | □ Yes □ No | |
| Parkinson's disease | □ Yes □ No | | Diabetes mellitus | □ Yes □ No | |
| Other neurological disorders | □ Yes □ No | | Heart attack | □ Yes □ No | |
| Liver disorders | □ Yes □ No | | Congestive heart failure | □ Yes □ No | |
| High cholesterol | □ Yes □ No | | Other heart condition | □ Yes □ No | |
| Asthma | □ Yes □ No | | Organ transplant | □ Yes □ No | |
| Other lung disorder | □ Yes □ No | | AIDS/HIV* | □ Yes □ No | |
| Cancer | □ Yes □ No | | Eating disorder | □ Yes □ No | |
| Tumors/ growths | □ Yes □ No | | Mental/emotional disorder | □ Yes □ No | |
| Hemophilia | □ Yes □ No | | Rheumatoid arthritis | □ Yes □ No | |

* "AIDS" means Acquired Immune Deficiency Syndrome. "HIV" means Human Immunodeficiency Virus.

3. If anyone listed above takes prescription medications (including fertility drugs), please explain below:

| Name | Drug and dosage | For what condition prescribed |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

4. If you are female, are you now pregnant? □ Yes □ No

   If yes, due date: _____

   Is the pregnancy high risk or expected to have complications? □ Yes □ No If yes, please explain: _____

   _____

5. Has any surgery, hospitalization, diagnostic testing or other medical treatment been received in the last 2 years or recommended for you? □ Yes □ No If yes, please explain:_____

   _____

   _____

   _____

6. Have you been turned down for health coverage by any insurer or health plan?
   □ Yes □ No If yes, please explain_____

   _____

   _____

   _____

7. Are you under 65 and covered by Medicare? □ Yes □ No
   If yes, please explain:_____

   _____

**ACKNOWLEDGEMENT**

The information provided on this form is protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). FirstCarolinaCare Insurance Company (FCC) will safeguard my PHI and will not disclose it unless I request it or where the disclosure is permitted or required by state or federal law. The PHI provided on this form will be used to determine premium rates for the applicable employer group. I understand that I cannot be declined for coverage based on the information I provide on this form. I understand that by signing this form I attest that all the answers are accurate and complete. I further understand that coverage will be issued in reliance upon the information herein. Any untrue or incomplete information, whether intentional or not, may result in a premium adjustment.

_____ _____

Employee/ Covered Spouse Signature Date