Hypertension (HBP) Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, VA 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date:_____

_____ **Return by:** _____

_____

_____ **Underwriting Specialist:**_____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information regarding the health status of _____. **(You may use additional paper if necessary. All additional sheets must be signed and dated by the applicant). PLEASE INITIAL AND DATE ANY ALTERATIONS.**

1. Physician who supervises the hypertension:
   Name: _____ Address: _____ Phone # _____
2. Date last seen by any physician for this condition: ____/____/____
3. Date diagnosed with this condition: ____/____/____
4. Has any physician either prescribed or dispensed medication(s) for this condition? ☐ Yes ☐ No
   If yes, please give date: ____/____/____
   Is this person currently taking medication? ☐ Yes ☐ No Name of medication(s):_____
   If not currently taking medication, please explain why: _____
5. List all blood pressure readings taken by a physician or licensed medical facility within the past 12 months.

Blood Pressure Reading	Date	Blood Pressure Reading	Date
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___
_____	___/___/___	_____	___/___/___

6. Has this person ever experienced any of the following conditions and/or complications?

1) Heart Failure	☐ Yes	☐ No	5) Arteriosclerotic heart disease	☐ Yes	☐ No
2) Retinal hemorrhage	☐ Yes	☐ No	6) Kidney failure	☐ Yes	☐ No
3) Stroke	☐ Yes	☐ No	7) Elevated triglycerides and/or cholesterol	☐ Yes	☐ No
4) Diabetes	☐ Yes	☐ No	8) Other related complications	☐ Yes	☐ No

For each item checked **YES** in question 6, please explain in the chart below:

Question #	Condition/Diagnosis	Treatment	Date(s) of Condition

(continued on next page)

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

_____ Date_____/_____/_____
Signature of Applicant or Legal Representative mo. / day / year

_____ Date_____/_____/_____
Signature of Spouse or Other Adult to be covered (if applying for coverage) mo. / day / year