

Bluegrass Family Health

Medical Underwriting Application

(Supplemental Large Group Underwriting Form)

Social Security Number: _____ Last Name: _____ First Name: _____ Initial: _____

When explaining answers, please include details such as names, dates and diagnosis.
Attach additional pages of explanation if necessary

1) Have you or any dependents had claims exceeding \$5,000 over the past 24 months or been recommended for surgery? Yes [] No []
If yes, please explain _____

2) Have you or your dependents been admitted within the last 24 months, is currently admitted, or is anticipating admission to a hospital, nursing home or other medical facility for treatment? Are you currently off work for any reason? Yes [] No []
If Yes, please explain. _____

3) Are you or any of your dependents pregnant? If YES, please provide name, relationship, due date of child and any complications to date. Yes [] No []

4) Have you or any of your dependents seen a physician for any medical condition within the last two years? Yes [] No []
If Yes, please explain. _____

5) Have you or any of your dependents taken any prescription medication in the past 12 months? If YES, please list the medications, dates taken and those taking them. Yes [] No []

Authorization

The information on this form is true to the best of my knowledge. I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan contract. I agree to abide by the terms and conditions governing membership and receipt of services in the plan in which I have enrolled. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Signature: _____

Date: _____

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