Mailing Address:
175 Scott Swamp Road
PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to SOLO® Application
GENERAL HEALTH QUESTIONNAIRE

1. Name of Primary Applicant: _____. ID/SSN: _____.

2. Patient Name: _____.

3. Name of physician filling out this form(print clearly): _____.

4. Current Height in office (Feet/Inches): _____.

5. Current Weight in office (Pounds), with or without shoes? _____.

6. Blood Pressure in Office: _____.

7. Have there been any abnormal lab results during the last 5 years (i.e. cholesterol, blood glucose, etc.)? Yes or No: _____. **If yes**, please attach a copy of these results to this Questionnaire. **If no**, or if this is the first time you are seeing this patient, were any tests ordered but not yet reported?
   _____
   _____.

8. Has this patient been experiencing **any** symptoms (including, for example: snoring, night sweats, rashes, shortness of breath, dizziness, chest tightness, vision problems, etc.) that he/she has not previously had checked by a physician? Yes or No: _____. **If yes**, please list the symptom(s) and what follow-up, if any, is planned.
   _____
   _____
   _____.

For review and processing, please return this information in the envelope provided or for rapid processing, you may send this information to our confidential fax at: (860)-674-2862.

*********Please keep in mind that the more information we have and the more recent the information is, the sooner a final decision can be made regarding eligibility for insurance coverage.***

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my patient's application for consideration of coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Physician Address and Phone Number (print clearly):_____.

Physician Signature: _____.

Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
ALCOHOL & DRUG QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Have you ever used any of the following substances (YES OR NO)? If yes, please indicate which type.
   A). Alcohol (beer, wine or liquor): _____.
   B). Narcotics (heroin, opium, Demerol or their derivatives): _____.
   C). Hallucinogens (LSD,PCP,DMT, STP or derivatives): _____.
   D). Stimulants (cocaine, crack, amphetamines, anti-depressants): _____.
   E). Depressants (bromides, barbiturates or their derivatives): _____.
   F). Tranquilizers (Valium, Librium, Haldol or their derivatives): _____.
   G). Marijuana (hash, pot, grass, tea or their derivatives): _____.
   H). Intravenous drug use: _____.
   I). Indicate any other substance not listed above: _____.

****If you are presently using any of the substance(s) indicated above, please explain how much and how often. If you are not, when did you stop using the substance(s) indicated above?**

_____.

2. Have you had a DUI, OUI or OWI within the last 5 years? Yes or No _____. If yes, please provide the date and number of occurrences: _____.

3. Have you undergone treatment for substance/alcohol use/abuse/dependency? Yes or No: _____. If yes, please indicate:
   a. Type of treatment (hospitalization, medication, psychotherapy, counseling, etc.):
   _____.
   b. Date of treatment, length of treatment and date treatment ended: _____.
   c. Name, address and phone number of treating counselor, facility or physician:
   _____.

4. Have you, in the past 10 years been a member of Alcoholics Anonymous, Narcotics Anonymous, or similar aftercare programs? Yes or No: _____. If yes, are you an active member? Yes or No: _____. If inactive member, when was the date last attended? _____.

5. Have you ever been diagnosed with or told you had a problem with any substances including alcohol? Yes or No: _____. If yes, please give details: _____.

6. Have you had a Liver Function or Liver Enzyme Test? Yes or No: _____. If yes, provide the date and results of the most recent test: Date _____. Results _____.

7. Has there been any history of (YES OR NO):
   _____ Heart problems _____ Gastritis/ulcers _____ Depression _____ Kidney/liver disease

**Please explain any "YES" answers above:

_____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of applicant (parent/guardian if under 18): _____. Today's Date: _____.

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Supplement to SOLO® Application
BACK/NECK/SHOULDER PAIN QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Have you ever had pain, a strain/sprain in your back, neck or shoulder(s) or have ruptured or had a bulged, herniated or slipped disc? Yes or No: _____. If yes, complete the following:
   a. How many times: _____.
   b. Date of first episode: _____.
   c. Date of last episode: _____.

2. What area(s) involved? (Check appropriate areas):
   __Neck (cervical) __Middle (thoracic) __Low (lumbosacral)

3. Does the pain radiate? Yes or No: _____. If yes, where? _____.

4. What was the diagnosis? _____. Date of last symptom? _____.

5. Was this the result of an injury? Yes or No: _____. If yes, please provide details:
   _____.

6. Do you currently take prescription medication? Yes or No: ____. If yes, provide the name, dosage and frequency with which you take it:
   _____.

7. Have you ever had or been advised to have surgery/or spinal fusion? Yes or No: _____.
   If yes, please explain when and give details:
   _____.

8. Have you ever had or now have chiropractic treatment or physical therapy? Yes or No: _____. If yes, how often do you go? _____. Date last seen? _____.

9. What is your current occupation? _____. Have you ever lost time from work? Yes or No: _____. If yes, how long were you off work? _____. When did you return to work? _____.

10. Has further treatment or surgery been advised? Yes or No: _____. If yes, please give details:
    _____.

11. Do you have any residuals or limitations? Yes or No: _____. If yes, please explain:
    _____.

12. Please provide the name and address of the current treating physician:
    _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____.
Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
GASTROINTESTINAL QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check off all that apply:

__ Gastroesophageal Reflux (GERD)	__Esophageal Spasm	__Ulcer-Type: _____.
__ Esophageal Stricture/Spasm	__Reflux Esophagitis	__Ulcerative Colitis
__ Esophagitis	__Hiatal Hernia	__Diverticulosis
__ Difficult swallowing (Dysphagia)	__IBS	__Diverticulitis
__Spastic Colon	__Celiac Sprue	__Other: _____.

2. Date of diagnosis? _____. Date of last symptom? _____. Please indicate what symptoms you experienced (heartburn, palpitations, chest pains, etc.):
   _____.

3. What was the cause of this condition (if any)? _____.

4. How many occurrences have you had of this condition in the last 2 years? _____. When was the date of your last occurrence? _____.

5. Have you ever been hospitalized or gone to the emergency room for this condition or any other related condition? Yes or No: _____. If yes, how many times, when, and the location?
   _____.

6. Was medication prescribed? Yes or No: _____. If yes, what is the name of the medication, dosage and frequency with which you take it or have taken it? _____.

7. Were any tests taken related to this condition (x-rays, Upper GI, ultrasound, colonoscopy, sigmoidoscopy, barium enema, biopsy, endoscopy, etc.)? Yes or No: _____. If yes, please indicate the type of test(s): _____. When? _____. Results (benign or malignant): _____.

8. Have you had surgery for this or any other related condition, or do you plan to have surgery in the future? Yes or No: _____. If yes, when? _____.

9. Have you made dietary changes? Yes or No: _____.

10. How has this condition impacted your activities of daily living?
    _____.

Please provide the name and address of the treating physician for the condition(s) above:
_____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____. Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
GYNECOLOGICAL SERVICES QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check off all that apply:
   __Abnormal Pap Smear/Mammogram __Endometriosis __Fibroid(s)
   __Infertility __PCOD/PCOS __Cyst, lump, mass, nodule
   __Ectopic pregnancy __Abortion/miscarriage __Menorrhagia/Metrorrhagia
   __Cervical Cancer/Dysplasia __Current Pregnancy __Other: _____.

2. Date of diagnosis: _____.

3. Cause (if known): _____.

4. Date of last symptom: _____.

5. What type of treatment(s)/testing have you had or did you have?

Procedure	**Date**	**Results**(benign/malignant)
_____	_____	_____
_____	_____	_____

6. If you were prescribed medication, please provide the name, dosage, and frequency with which you took it or are taking it. _____.

7. Have you had a Mammogram/Pap smear since the original diagnosis or treatment? Yes or No: _____. If yes, when and what were the results: _____.

8. Name and address of the treating physician:
   _____
   _____.

9. Do you have any plans for further treatment or surgery? Yes or No _____. If yes, please provide details. _____.

10. Are you pregnant currently? Yes or No: _____. If no, when was your last menstrual period(mm/dd/yyyy)? _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of applicant (parent/guardian if under 18): _____. Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
HEADACHE QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Date of diagnosis or first symptoms: _____.

2. Frequency of headaches:
   Number per week: _____.
   Number per month: _____.
   How long do they last? _____.

3. Are your headaches mild, moderate or severe? _____. Date of your last headache? _____.

4. Have you lost any time from work or been told to restrict any activities? Yes or No: _____. If yes, please provide details:
   _____.

5. Are you taking medication for this condition? Yes or No: _____. If yes, please provide the name of medication, dosage, and the frequency with which you take it:
   _____.

6. How often do you see the doctor for this condition? _____. Has he/she advised you to have any further testing or surgeries? Yes or No: _____. If yes, please explain:
   _____.

7. Please provide the name, date, and results of any special test/studies done (MRI, CT Scan, etc.):

Name of test/study:	**Date of test/study & Results**:
_____	_____
_____	_____
_____	_____

8. Are the headaches caused by an eyestrain, sinus infection, hypertension, brain tumor, aneurysm, trauma, acute febrile illness or temporal arteritis? Yes or No: _____. If yes, please provide details:
   _____.

9. Please provide the name and address of the most current treating physician for this condition:
   _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent / guardian if under 18): _____. Today's date: _____.

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Supplement to ConnectiCare® SOLO Application
HEART MURMUR/ MITRAL VALVE PROLAPSE QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.
1. Give exact diagnosis: _____. Date of diagnosis: _____.

2. Description/type of murmur (check one):
__Functional __Organic __Diastolic __Systolic __Atrial/Ventricular Septal Defect

3. Have you had any of the following tests? If yes, when and what were the results?

EKG	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Echocardiogram (Echo)	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Doppler Test	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Heart Catherization	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Holter Monitor	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Thallium	Yes __ No __	_____	Normal __ Abnormal __ Unknown __
Stress/ Treadmill	Yes __ No __	_____	Normal __ Abnormal __ Unknown __

4. Have you ever experienced symptoms such as chest pain, shortness of breath, dizziness, palpitations, irregular heartbeat, etc.? Yes or No: _____. If yes, please give details (date of onset, frequency, and severity):
_____.

5. What was the date of your last symptom? _____.

6. Have you ever taken medication for this condition? Yes or No: _____. If yes, please provide the name of the medication, dosage and the frequency with which you take it: _____.
If no longer taking, date stopped: _____.

7. Have you ever had surgery or had surgery or any other treatment recommended for this or any other related condition? Yes or No: _____. If yes, give details:
_____.

8. Have there been any hospitalizations for this or any other related condition? Yes or No: _____.
If yes, provide dates of confinement(s), length of stay(s), and the name and address of hospital(s) where confined:
_____
_____.

9. Do you have any other cardiovascular conditions? Yes or No: _____. If yes, provide complete details:
_____.

10. Name and address of current treating physician:
_____.
All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under18): _____. Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
HYPERTENSION/ HIGH CHOLESTEROL QUESTIONNAIRE

HYPERTENSION SECTION:

Name of applicant: _____. ID/SSN: _____.

Name of person related to the condition: _____.
Name of person filling out the questionnaire: _____.

1. When were you diagnosed with high blood pressure? _____. What was your blood pressure reading at that time? _____. What is your blood pressure reading today? _____.

2. Are you taking medication(s) for your blood pressure? _____. If yes, give the name of medication, dosage, and the frequency with which you take it:
   _____. If no, have you made dietary changes? _____. What dietary changes have you made? _____.

3. How many times in one calendar year do you see your doctor for blood pressure checkups?
   _____.

4. Please provide your **last 5 blood pressure readings** from your doctor and the **dates of those readings**:
   _____.
   If you monitor your blood pressure at home, what have been your last 5 blood pressure readings?
   _____.

5. Do you have any history of the following (circle all that apply):

Circulatory Disorder	Yes or No: _____.
Kidney disease	Yes or No: _____.
Diabetes	Yes or No: _____.
Heart disorder / murmurs	Yes or No: _____.
Cerebrovascular disease (Stroke, TIA)	Yes or No: _____.
Valve problems or enlarged heart	Yes or No: _____.

   Please explain any "yes" answers:
   _____
   _____.

HIGH CHOLESTEROL SECTION:

1. Do you have high cholesterol? _____. If yes, when were you diagnosed? _____.
2. What is your most recent reading/value for the following:

LDL (bad): _____	Date: _____
HDL (good): _____	Date: _____
Total Cholesterol: _____	Date: _____
Triglycerides: _____	Date: _____

3. Has medication been prescribed to control your high cholesterol? _____.
4. If yes to question 3, what is the name, dosage, and frequency of the medication you are taking?
   _____.
5. Please provide the name and address of your current treating physician:
   _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will rely on the information I provide in this form when determining any eligibility for SOLO coverage.

Signature of Applicant (parent/guardian if under 18): _____. Date: _____.

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Supplement to ConnectiCare® SOLO Application
MENTAL HEALTH QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check off one of the following conditions that best applies to you:
   __Schizophrenia __Major/Minor Depression __Anorexia/Bulimia
   __OCD __Stress/Anxiety __Bipolar Disorder
   __Situational Depression __Manic Depression __ADD/ADHD
   __Other: _____.

2. Please check all of the symptoms you have experienced related to your condition:
   __Fatigue __Nervousness __Mood swings
   __Loss of appetite __Suicidal thoughts __Sadness
   __Insomnia __Inability to concentrate __weight loss/gain
   __Heart palpitations __Other: _____.

3. When were you diagnosed? _____. Date of your last symptom? _____.

4. Please check off your treatment type from the following (if more than one type indicate so):
   __Psychologist __Psychiatrist __Physician
   __Medication __Inpatient therapy __outpatient therapy
   __Counselor __Other _____.

5. When did your treatment begin? _____Has your treatment stopped? Yes or No ____. If yes, when did the treatment stop? _____. If no, how often does this treatment take place? _____.

5. If your treatment is medication, please provide the name of the medication, the dosage and the frequency with which you take it. _____. Have you had any medication changes in the past 6 months? Yes or No: _____. If yes, please explain(when, what from-what to, any plans for further changes, etc.):
   _____.

6. Have you been hospitalized for this, or a similar condition? Yes No. _____. If yes, provide complete details regarding date(s) of hospitalization, duration of stay and name of facility:
   _____.

7. Are you currently in therapy of any kind? Yes or no: _____. Type (psychotherapy, counseling, facility, etc.): _____.

Please provide the name, address, and phone number of the most recent treating physician or health care practitioner seen for this condition:
_____.
All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____.Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
MUSCULOSKELETAL QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.
Name of person related to condition: _____.

1. Please check off all that apply:

__Spina Bifida	__DDD/DJD	__Scoliosis
__Radiculitis	__Spondylitis/Spondylolisthesis	__Tendonitis/Tenosynovitis
__Bursitis	__Rheumatoid Arthritis	__Gout-Location: _____.
__Osteoarthritis	__Fracture/Broken bone	__Sciatica/Pinched nerve
__Fibromyalgia	__Carpel Tunnel Syndrome	__Osteoporosis/Osteopenia
__Rotator Cuff	__Polymyalgia/Myositis	__Other: _____.

2. What was the date of diagnosis? _____. Date of last symptom? _____. What caused your condition? _____.

3. How are you being treated for this condition(check all that apply):
   __Medication (name/dosage/frequency) __Chiropractic care (dates/frequency)
   __Physical therapy (dates/frequency) __Other: _____.

   Please provide details to the treatments checked above:
   _____.

4. Have you ever had or been advised to have surgery or spinal fusion? Yes or No: ____. If yes, please explain (dates, etc.): _____.

5. Do you require the use of cane, crutches or a wheelchair to move about? Yes or No: _____.

6. Have you ever had loss of time at work or restriction of activities? Yes or No: _____. If yes, please explain (dates, etc.): _____.

7. Has any further treatment or surgery been recommended? Yes or No: _____. If yes, please explain:
   _____.

8. Have you had a history of depression, anxiety or any other psychological condition not previously disclosed? Yes or No: _____. If yes, what was the diagnosis? _____. If any medications were required, please provide name, dosage and frequency taken:
   _____.

9. Have you completely recovered without any residuals or limitations? Yes or No: _____. If no, please explain:
   _____.

10. Please provide the names and addresses of the treating physicians for all conditions checked above:
    _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____. Today's Date: _____.

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Supplement to SOLO® Application
MOTOR VEHICLE ACCIDENT QUESTIONNAIRE

1. Name of Primary Applicant: _____. ID/SSN: _____.

2. Name of person related to condition: _____.

3. When was the date of your motor vehicle accident? _____.

4. What was your final diagnosis? _____.

5. Did you loose consciousness? Yes or No: _____. If yes, how long were you unconscious? _____.

6. Other than your final diagnosis, was there any other part of your body that was injured? Yes or No: _____. If yes, what part of the body and how were you treated for this injury? _____.

7. Were you hospitalized? Yes or No: _____. If yes, how long were you in the hospital? _____.

8. Are you currently being treated for the injuries sustained in the motor vehicle accident? Yes or No: _____. If yes, what type of treatment are you receiving and how often?
   __Medication __Chiropractic Care __Physical Therapy __Other: _____.
   Please provide specific details to your treatment below:
   _____.

9. Has/Had the doctor recommend surgery for your injuries? Yes or No: _____. If yes, what is/was the date of your surgery? _____. If no, do you currently have plans for further treatment or surgery? Yes or No: _____. If yes, when? _____.

10. Have you completely recovered from your injuries without any residuals or limitations? Yes or No: _____. If no, please give specific details (use of a cane, crutches, cast, hardware in place, etc.):
    _____.

11. How much time did you loose from work? _____.

12. Please provide the name and address of all treating physicians related to your injuries below and any further details you may want to provide:
    _____
    _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____.Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
RESPIRATORY QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check all that apply to you:
   __Asthma __Allergies __COPD
   __Chronic Bronchitis __Emphysema __Pneumonia
   __Deviated septum __Pleurisy __Pneumothorax
   __Sleep Apnea __Other: _____.

2. Date of diagnosis? _____. Date of last symptom: _____.

3. Check all that apply to you:
   __Frequent wheezing __Wheezing when talking __Wheezing when resting

4. Please indicate all medications you are taking, their names, dosages, and the frequency with which you are taking them (if supplemental oxygen use or Nebulizer or allergy shots please indicate):
   _____.

5. How many attacks have you had per year? _____. When was the date of your last attack? _____. Has surgery been recommended to correct this condition? Yes or No: _____.

6. Have you had an asthma attack requiring doctor's visit, hospitalization(s) or emergency room visits for this condition? ___Yes ___ No If yes, provide details to the following:
   a. Reason for seeking treatment or confinement? _____.
   b. Date(s) of confinement/visits: _____.
   c. Number of visits/confinements: _____.
   d. Name and address of doctor/hospital where seen:
   _____.

7. Any work loss or restricted activities? Yes or No: _____. If yes, please explain:
   _____.

8. Please check all that apply and indicate results here: _____.
   __Allergy-testing __X-ray studies __Specialist's exam
   __Bronchoscopy __Pulmonary function test __Other: _____.

9. How often do you see the doctor for this condition? _____. Please provide his/her name and address:
   _____.

10. Are you currently using tobacco products? Yes or No: _____. If yes, how much/how often do you use them? _____. If no, when did you quit? _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18) below: _____. Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
SEIZURE/EPILEPSY QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please indicate type of seizure:
   __Grand Mal __Petit Mal __Jacksonian
   __Febrile __Myoclonic __Partial
   __Other (specify): _____.

2. Please provide the details of your symptoms:
   _____
   _____.

3. Date of diagnosis: _____. Date of last episode: _____.
   Date of first seizure: _____. Frequency of seizures: _____.

4. Please provide details of treatment including any tests or special studies and the results:
   _____
   _____.

5. Have you ever been hospitalized because of seizures? Yes or No: _____. If yes, please provide complete details regarding dates of hospitalization(s), duration of stay(s) and treatment(s) received:
   _____
   _____.

6. Are you taking medication(s) for this condition? Yes or No: _____. If yes, please provide the name of the medication, dosage and frequency with which you take it:
   _____.
   If no, did your doctor recommend discontinuation? Yes or No: _____. If yes, please provide the date of discontinuation: _____.

7. Please provide the name and address of the treating physician: _____
   _____.

8. Have you lost any time from work or have you had to make any restrictions to your activities: Yes or No: _____. If yes, please explain:
   _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____. Today's Date: _____.

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Supplement to ConnectiCare® SOLO Application
THYROID QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check all that apply:
   __Hypothyroidism __Hyperthyroidism __Goiter
   __Nodule __Hashimoto's Thyroiditis __Other: _____.

2. Date of diagnosis: _____. Date of last symptom: _____.

3. How are you currently being treated for this condition? If medication, please provide the name, dosage and frequency with which you take it.
   _____.

4. Have you ever had or been advised to have surgery? Yes or No: _____. If yes, please give dates and details: _____.

5. Was the last thyroid level within range? Yes or No: _____. Please provide the results of last thyroid level test/study and date checked:
   _____. ****If you do not remember, please attach a copy of your most recent lab report to this form.

6. Please indicate the name and address of your current treating physician:
   _____.

7. Please provide any other details:
   _____
   _____
   _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____.

Today's Date: _____.

Mailing Address:
175 Scott Swamp Road
PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to ConnectiCare® SOLO Application
TUMOR/SKIN QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.
Name of person related to condition: _____.

1. Please check all that apply related to your diagnosis:

__Actinic Keratosis	__Basal Cell Carcinoma	__Squamous Cell Carcinoma
__Skin Tags	__Tumor or Cyst	__Eczema
__Acne	__Psoriasis	__Melanoma
__Moles	__Other: _____.	

2. Was the lesion diagnosed as malignant or benign? (If malignant, provide details: i.e. stage, grade, Clark level (Melanoma), Class (Tumor) or Gleason (Prostate) score.
   _____.
3. Size of tumor/cyst/skin lesion? _____. Location(s)? _____. What is the severity of this skin disorder (mild, moderate or severe)? _____.
4. Has there been any metastasis or spread to any other location(s)? Yes or No: _____. If yes, please provide details: _____.
5. Has there been a recurrence, relapse or multiple episodes of any lesions including warts? Yes or No: _____. If yes, please provide details (how many in the last 12 months, etc.):
   _____.
6. Did you receive medication for the tumor/cyst/skin lesion? Yes or No: _____. If yes, please provide name, dosage, and frequency with which you take it or have taken it:
   _____.
7. Did you receive radiation or chemotherapy for the tumor/cyst/skin lesion? Yes or No: _____. If yes, please provide details and date(s) taken: _____.
8. Have you had surgery or been advised to have surgery to remove the tumor/cyst/skin lesion? Yes or No: _____. If surgery done, when? _____. Have you been released from treatment? Yes or No: _____. If yes, when? _____.
9. Are further studies or future operations for the tumor/cyst/skin lesions anticipated? Yes or No: _____. If yes, what type and when? _____.
10. Are there any other lesions on your body that have not been checked by a physician? Yes or No: _____. Please provide any other pertinent details:
    _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Person related to condition (parent/guardian if under 18):_____.
Today's Date: _____.

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PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to ConnectiCare® SOLO Application
URINARY/PROSTATE DISORDER QUESTIONNAIRE

Name of primary applicant: _____. ID/SSN: _____.

Name of person related to condition: _____.

1. Please check all that apply:
   __Bladder infection/UTI __Cystitis __Incontinence __Stones
   __Nephritis __Prostatitis __Polycystic Kidney
   __Benign Prostate Hyperplasia __Other: _____.

2. When were you diagnosed? _____. When was the date of your last symptom? _____.

3. How many occurrences have you had in the past year? _____. When was the date of your last occurrence? _____. Is there a stone present? Yes or No: _____.

4. Have you had or been told to have any operations or procedures related to this condition? Yes or No: _____. If yes, what type and when?: _____.

5. Do you now have or have you ever had any heart trouble or high blood pressure? Yes or No (If yes, please provide dates and details):
   _____
   _____.

6. What special tests/studies have you had (provide name, dates and results of studies)?
   _____.

7. When did you have your urine last checked? _____. What were the results?
   _____. *****If you do not know the results, please attach your most recent urinalysis report to this form.**

8. Please provide the name and address of your current treating physician:
   _____.

9. Please give any other details:
   _____
   _____
   _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (parent/guardian if under 18): _____.

Today's Date: _____.