HIGHMARK Delaware

Highmark Blue Cross Blue Shield Delaware
P.O. Box 1991
Wilmington, DE 19899-1991
Visit our website at: highmarkbcbsde.com

MEDICAL HISTORY FORM

Employee Name (First, Last)	Social Security Number	Coverage Type	Date of Birth (myself)
❑ **Myself** — Gender: Height: Weight:	❑ **My Spouse*** — Gender: Height: Weight:		Date of Birth (spouse)

1. Please answer each of the medical questions below for all applicants. If answer is Yes - provide details in section 2 below:
Have you or any of your dependents applying for coverage ever had or been advised that you or they have any of the following:

❑ YES ❑ NO a. Chronic back, muscle or skeletal pain or disorder
❑ YES ❑ NO b. Heart condition including chest pain or high blood pressure
❑ YES ❑ NO c. Stroke or other circulatory disorder
❑ YES ❑ NO d. Cancer or tumors (benign or malignant, including lymph node disorders)
❑ YES ❑ NO e. Lung or other respiratory disorder
❑ YES ❑ NO f. Thyroid disorder
❑ YES ❑ NO g. Kidney or urinary system disorder
❑ YES ❑ NO h. Liver or digestive system disorder (including ulcers or intestinal disorders)
❑ YES ❑ NO i. Diabetes (indicate Type I or Type II)
❑ YES ❑ NO j. Substance abuse or dependency
❑ YES ❑ NO k. Emotional or psychological disorder including anxiety, depression, bi-polar, etc.
❑ YES ❑ NO l. Excessive alcohol use or dependency or been advised to reduce intake
❑ YES ❑ NO m. Immune system disorder (HIV, AIDS, ARC, etc.)
❑ YES ❑ NO n. Sexually transmitted disease (including Herpes)
❑ YES ❑ NO o. Elevated cholesterol
❑ YES ❑ NO p. ADD or ADHD
❑ YES ❑ NO q. Brain or nervous system disorder
❑ YES ❑ NO r. Organ transplant recipient or on a transplant waiting list
❑ YES ❑ NO s. Involved in a motor vehicle accident in the last 3 years
❑ YES ❑ NO t. Weight gain or loss of over 20 pounds in the last year
❑ YES ❑ NO u. Currently pregnant or undergoing infertility treatment (indicate due date below)
❑ YES ❑ NO v. Hospitalized or had surgery in last 5 years
❑ YES ❑ NO w. Prosthetic device or implant
❑ YES ❑ NO x. Abnormal test results in the last 12 months, awaiting test results or been advised to have tests or exams.
❑ YES ❑ NO y. Other disorder or condition not already mentioned
❑ YES ❑ NO z. Use of tobacco product during past 24 months

2. Please provide details regarding 'Yes' answers above.

Ques. No.	Name of Applicant	Condition or Diagnosis	Treated From MM/YY	Treated To MM/YY	Explain Treatment including Surgery, Test Results, and Medication	Degree of Recovery (100%, Partial, Ongoing Issue)

3. Please provide information below regarding any prescription medication you or any dependent applying for coverage has been prescribed in the last year. (other than those already mentioned in 2 above.)

Name of Applicant	Condition or Diagnosis	Treated From MM/YY	Treated To MM/YY	Medication	Dosage

I certify that all information above is true and complete to the best of my knowledge and belief, and understand that my coverage may be void if this is not correct. ***I, on behalf of myself and my covered dependents,*** authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to Highmark DE or its designee for purposes reasonably related to this contract. Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a claim containing any false, incomplete or misleading information may be guilty of a felony.

Signature: ______________________________ **Date:** _______/_______/_______

**Important Note: As of January 1, 2012, the definition of spouse includes a civil union partner.*