Group Employer Medical Questionnaire

Blue Cross and Blue Shield of Oklahoma
P.O. Box 3283
Tulsa, OK 74102-3283

Complete the following questions to the best of your knowledge for eligible employees, their dependents, and any COBRA participants, state continuation participants, or state dependent continuation participants. If your current carrier is Blue Cross and Blue Shield of Oklahoma, your response to the medical questions should be based on eligible employees and/or dependents not currently on your employee group health plan. If BCBSOK is your current carrier, provide your Group/Account Health Number.

1. How many employees or dependents have had a claim of $5000 or more in the past 12 months? _____

2. How many employees or dependents have been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years? _____

3. How many employees or dependents have been advised, diagnosed, or treated by a physician in the past 5 years for (Enter the **number** of employees or dependents with the condition and provide details on the next page.):

A.	_____ Stroke _____ Heart Disease or Disorder _____ Circulatory Disease or Disorder	_____ Vascular Disease or Disorder _____ High Blood Pressure	
B.	_____ Cancer _____ Tumors _____ Leukemia	_____ Lupus _____ Chronic Skin Condition _____ Any other Systemic Disease	
C.	_____ Multiple Sclerosis _____ Paralysis _____ Osteoarthritis _____ Other Severe Arthritis	_____ Joint Disorders _____ Back Disorders _____ Muscle Disorders _____ Bone Disorders	
D.	_____ Asthma _____ Emphysema	_____ Respiratory and Lung Disorders	
E.	_____ Diabetes _____ Pancreas	_____ Growth Disorder _____ Endocrine Disorder	
F.	_____ AIDS _____ Tested Positive for HIV	_____ Immune System Disorders _____ Blood Disorders	
G.	_____ Hepatitis _____ Liver Disorder _____ Digestive System Disease or Disorder _____ Colon Disorder	_____ Kidney Disorder _____ Prostate Disorder _____ Reproductive Organ Disorder _____ Infertility _____ Urinary Tract Disorder	
H.	_____ Nervous System/Brain/ Seizure Disorders _____ Mental/Emotional Disorders	_____ Alcohol/Drug/Substance Abuse or Dependency	
I.	_____ Organ Transplant	_____ Bone Marrow Transplant	
J.	_____ Other		

4. How many employees or dependents are currently pregnant? _____

If you have indicated medical conditions on the previous page, please provide details for each person with the condition. If more than one person has the condition, add a separate entry for each person. See the example in the first line.

Name of Person with Condition (Optional)	Age	Gender	Relation to Insured*	Condition/ Diagnosis Details	Treatment/ Medication Details	Date(s) Treated	Current Status
John Doe "Example"	12	M	Child	Appendicitis	Surgery to remove appendix	01/01/99 to 01/05/99	Full recovery

* Employee, Spouse, Child

I understand the information on this form and any other medical information provided to BCBSOK in prior preliminary medical requests or otherwise provided to BCBSOK, is the basis for premium determination by BCBSOK for the health plan. I acknowledge that false statements or material misrepresentations may result in legal consequences. I certify the information is complete and true to the best of my knowledge.

Authorized Company Official's initials here: _____ Agent's initials here, if applicable: _____