Questions? Call us at Avenue Insurance Planners at 800.240.3390

Tips for completing the application:

1. Please read everything carefully and answer all questions honestly. This document becomes part of your health insurance contract.
2. Please complete all sections to the best of your ability. Remember to fill out the Washington Standard Health Statement. ***One health statement per person applying for coverage***! This may not be required, please refer to the Standard Health Questionnaire for who is exempt from completing the questionnaire. Please pay special attention to the Health History Section.

Prior Insurance?

Yes:
Please make a photocopy of your health insurance card(s) or contact your insurance carrier and request a “Certificate of Credible Coverage.” Include this with your application.
No:
If your application is approved, when the policy is sent to you, there will be a form that will need to be a 9 month waiting period on pre-existing conditions. There is a 12 month waiting period for Transplants.

Payment:

The payment options are monthly bank draft or direct bill.
Monthly Bank Draft:
Please complete Authorization section carefully and attach a voided check.
Direct Bill:
Simply check the Direct Bill, and you are done.

Final check list before mailing:

- All sections completed?
- Copy of Insurance Card or Certificate of Credible Coverage
- Signed and Dated
- Voided check if selecting the automated monthly withdrawal

Send Completed Application to:

Avenue Insurance Planners
PO Box 1483
Veradale, WA 99037

Washington Individual Enrollment Application (Non-grandfathered)

Effective January 1, 2011

LIFEWISE
HEALTH PLAN OF WASHINGTON

Please print your answers clearly in ink so we can process your application quickly.

1 Am I Eligible?

You're eligible to apply for a LifeWise plan if you are:

- A resident of and have a principal residence in the state of Washington; and
- Not entitled to Medicare
  - If you are 65 or older but not eligible for Medicare, please submit a "Not Eligible for Medicare" document from the Social Security Administration.

If you are 19 years of age or older, you can apply anytime throughout the year. If you or your dependents are under the age of 19, please refer to the table below to determine when you can apply.

Eligible Applicants	Eligible to apply throughout the year?	Able to apply as a subscriber on your own policy?	Additional Information
Applicants that are 19 years of age and older	Yes	Yes	Applicants that are 19 years of age and older can apply for coverage anytime.
Applicants under the age of 19	No—only during an open enrollment period	Yes	Applicants under the age of 19 can apply as a subscriber on their own plan or as a dependent* during an open enrollment period.**
Applicants under the age of 19 who have experienced an involuntary loss of coverage	Yes —within 31 days of when your prior coverage ended	Yes	Please call Customer Service to determine if your situation qualifies as an "involuntary loss of coverage."
Newborns or newly-adopted children	Yes—within 60 days of birth or placement for adoption; otherwise, only during an open enrollment period	Yes	If an application is submitted within the first 60 days of birth or placement, newborns or newly-adopted children may be added as a subscriber on their own plan or as a dependent,* outside of an open enrollment period.** After 60 days of birth or placement, the criteria associated with "applicants under the age of 19" applies as described above.

* Eligible dependents that can enroll on your plan include:

- Your spouse or domestic partner
- Your natural or legally adopted child(ren) under the age of 26
- Child(ren) under the age of 26 who is/are legally placed with you

** An open enrollment period is the timeframe set by the state of Washington when you can enroll your dependents under the age of 19. Please refer to **lifewisewa.com** for the dates of an open enrollment period. We must receive your completed enrollment application before the end of the open enrollment period. The effective date of coverage will ALWAYS be January 1 following the open enrollment period in which the application was received.

2 I'm filling out this application because I am…

☐ a new applicant

☐ **Yes** ☐ **No** If you are a new applicant, have you had prior coverage with LifeWise in the past 12 months?

☐ a current member adding: (select a box below)

☐ my spouse: ______________________ (marriage date)

☐ my domestic partner

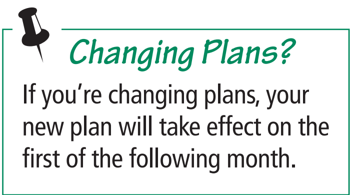
☐ a child(ren): ☐ Newborn

☐ Adopted: ______________________ (date of placement)

☐ changing my plan.

My subscriber ID# is:

______________________ (see your ID card)



3 Date my coverage should begin*

I want this plan to begin on the ☐ 1st **or** ☐ 15th of ______________________ (no more than 60 days after the application is signed)

(enter month)

4 I want to enroll my…

Name	Social Security Number / Date of Birth	Gender / Tobacco
Self (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 12 months:** ☐ Y ☐ N
Legal Spouse or Domestic Partner (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	**I used tobacco in the last 12 months:** ☐ Y ☐ N
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	
Dependent Child—under 26 only* (Last, First, Middle Initial)	Social Security Number (optional)	Gender: ☐ M ☐ F
	Date of Birth / /	

Address	City / State / ZIP	County	Telephone
Home Address (not P.O. Box) **required**	City / State / ZIP	County	Home Telephone Number ( )
Mailing Address (if different from Home Address)	City / State / ZIP	County	Work Telephone Number ( )
Billing Address (if different from Mailing Address)	City / State / ZIP	County	Cell Telephone Number ( )
E-mail Address of Primary Applicant			

* Applicants under 19 years of age who are subject to the open enrollment eligibility rules will have an effective date of January 1. Please see Section 1.

5 Selecting my health plan

I want to enroll in the…	…and I want this deductible: (check only one box)
WiseSimplicity plan	☐ $10,000*
WiseEssentials Rx plan	☐ $1,850* ☐ $2,500* ☐ $3,500*
WiseEssentials Copay plan	☐ $5,000* ☐ $7,500*
WiseChoices Prime plan	☐ $1,500
WiseSavings plan	☐ $1,840* (Individual) ☐ $3,680* (Family) ☐ $3,000* (Individual) ☐ $6,000* (Family)

* This is a catastrophic plan. Enrollment in a catastrophic health plan may not provide portability if you later decide to enroll in another individual health plan. "Portability" means that you will receive credit for a plan's pre-existing condition waiting period based on prior coverage.

Choose Only One

Check only **one plan deductible box** per application. If you want a family member to be on a different plan or deductible, complete a separate enrollment application.

6 Paying for my health plan (select one)

☐ Monthly paper bill by mail (move on to Section 7)

☐ Automatic monthly withdrawal from my bank account. Here's my account information:

I have selected automatic monthly withdrawal and I hereby authorize LifeWise to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)	Financial Institution or Bank Name
Financial Institution/Bank City, State, ZIP	☐ Checking ☐ Savings
Bank Routing Number (see picture below)	Account Number (see picture below)

Your Name
123 Main Street
Anytown, USA 12345
0001
DATE
PAY TO THE ORDER OF
$
DOLLARS
Notes
Attach your voided check HERE
⑆123456789⑆ 9876543210⑈ 0001

Bank Routing Number Account Number

Remember

A government agency or any other third party may not sponsor or pay for your Individual Health Plan, except as required by law.

Routing Number

We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

Additional Terms and Conditions:

- Funds are transferred on the 1st business day of each month to pay for that month's coverage. (For example, the deduction on February 1st pays for coverage in February.)
- I understand that if I choose the 15th of the month as my effective date, my first transfer amount will cover 15 days of the current month PLUS the next full month. The next transfer will not occur until the second full month of coverage.
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify LifeWise that it should be cancelled. To ensure prompt cancellation, I must notify LifeWise no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment of a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Account Holder Signature X ____________________ **Date of Signature** ____/____/____

7 Do I need to complete a Standard Health Questionnaire (SHQ)?

Each applicant 19 years of age or older must complete a Standard Health Questionnaire unless one of the following circumstances applies. For a detailed explanation on these exclusions, please refer to the first few pages of the Standard Health Questionnaire.

Important!

Unless you are positive that you satisfy one of these conditions, we need an SHQ from each applicant you want to enroll.

Check only one box if applicable. Be sure to attach your evidence of coverage based on the box you check below.

MY SITUATION	SUBMIT THE FOLLOWING DOCUMENTS
☐ **Relocation:** I changed residences from one part of Washington to another and my previous health plan doesn't cover my new area of residence.	• A copy of a utility bill in your name from the prior address that's dated within the last 90 days; **AND** • A verification letter from your prior carrier verifying that you no longer reside in their service area
☐ **Provider cancellation:** My physician or other healthcare provider left my previous Individual health plan's provider network within the past 90 days but is a provider in the LifeWise network.	• A letter from your healthcare provider indicating that he/she has stopped being part of your current individual health plan's provider network within the last 90 days. This letter should also indicate: • That you have received services from that provider within the last 12 months prior to leaving your current health plan • The date the provider left the network • That your provider is part of LifeWise's provider network
☐ **COBRA** (not applicable to WA State Basic Health Plan applicants): In the past 90 days of the date of this application, I have either: • exhausted or terminated my COBRA continuation coverage; • experienced a COBRA qualifying event and I am choosing not to elect COBRA	• The Certificate of Coverage you received from your prior carrier showing 24 months of continuous coverage; **AND** • A letter from your prior employer indicating one of the following: a) you've exhausted COBRA coverage, b) you've terminated COBRA coverage, c) you've elected not to take COBRA coverage and the date of your COBRA qualifying event
☐ **Employer is exempt from offering COBRA:** In the past 90 days, I had a COBRA qualifying event that caused me to be terminated from my employer's group health plan. I was on this group coverage for at least 24 continuous months. My employer is exempt from offering COBRA so I'm seeking Individual health coverage.	• A letter from your employer or former employer indicating the start and end dates of your group coverage (including church plans), the date of the COBRA qualifying event, and that the employer group is not eligible for COBRA; **AND** • The Certificate of Coverage showing 24 months of continuous group coverage
☐ **WA State Basic Health Plan:** I'm applying within 90 days of losing my government-sponsored Washington Basic Health Plan coverage that I've had for at least 24 months. This does not include DSHS or Medicaid plans.	• A letter of verification from your prior carrier indicating that you were covered under WA State Basic Health Plan and your start and end dates of coverage showing 24 months of eligibility with WA State Basic Health Plan; **OR** • The Certificate of Coverage indicating the start and end dates of your WA State Basic Health Plan coverage.
☐ **Newborn/newly-adopted child addition:** I'm adding my newborn or newly-adopted child to my existing LifeWise plan, within 60 days of the birth or placement for adoption.	• A copy of the adoption or placement paperwork
☐ **Employer Business Closure:** I am applying within 90 days from the date my employer discontinued or will discontinue group health plan coverage due to business closure. I was on this group coverage for at least 24 continuous months, and I am requesting an effective date within 90 days of my group health plan being discontinued.	• A verification letter from your prior carrier with your start and end dates of coverage showing 24 months of eligibility; **AND** • A letter from your employer/former employer indicating the date of expected business closure.

Need additional copies of the Standard Health Questionnaire? You can download a copy from the "Forms" section on **lifewisewa.com**, call LifeWise Customer Service at 1-800-592-6804 or contact your producer to have one mailed to you.

8 Health Information

To identify applicants who may benefit from our health management programs, please complete the following questions.
Note: *Do not list individuals who will not be enrolled for coverage.*

A. ☐ **Yes** ☐ **No** Do you or any dependents have a disability, chronic health condition (i.e. diabetes, heart condition, etc.), or been advised in the last 12 months that hospitalization, surgery or treatment is needed or pending?

NAME	REASON

9 My Prior Health Coverage

Have you had coverage in the past 9 months?
☐ Yes (complete the information below) ☐ No (move on to Section 10)

Do you intend to continue this current coverage if you are accepted by LifeWise?
☐ Yes ☐ No (remember to cancel your current health plan, including our corporate affiliates.)

By reporting your prior coverage, we may waive or credit the nine-month waiting period for pre-existing conditions. To help us determine if you qualify, please complete the following information. We must receive this completed application within 63 days of your prior coverage ending. For more information on eligibility to get waiting periods waived, please see Section 11.

Prior Coverage?
Remember to attach your Certificate of Coverage or other documentation that verifies your prior coverage beginning and end dates. You can get it from your previous employer or health plan carrier.

Name of Your Previous or Current Health Plan Carrier	Telephone Number ( )
Name of Subscriber (contract holder)	Subscriber ID #
Names of All Enrollees on Prior Coverage	
Date Coverage Began / /	**Date Coverage Ended** / /
Deductible Amount $ per individual per year	Deductible Amount $ per family per year
Type of Coverage ☐ Individual ☐ Group ☐ Healthy Options ☐ Basic Health Plan ☐ WSHIP	
Type of Benefits (check all that apply) ☐ Medical ☐ Hospital Only ☐ Accident Only ☐ Prescription Drug ☐ Dental ☐ Vision	
Do you intend to continue this other coverage if you are accepted by LifeWise? (If no, remember to contact your insurance company to cancel, including our corporate affiliates) ☐ YES ☐ NO	

10 Basic Terms of Enrollment

1) I understand and agree that this application is not an offer of coverage, and coverage does not begin until: a) This application is received, reviewed, and accepted by LifeWise and an effective date of coverage is assigned; and b) My complete and correct payment is received. Submission of this application does not guarantee I will receive coverage.

2) I understand and agree that this application becomes a part of my plan and to the extent that the application is inconsistent with the plan, the plan will govern.

3) I understand that this plan has a nine-month waiting period for pre-existing conditions. No benefits are provided for any medical condition for which treatment was received (or recommended), or for which a prudent person would have sought advice or treatment within the six months prior to the effective date of this plan. This waiting period does not apply to: Individuals under the age of 19, formula for treatment of phenylketonuria, and prenatal care (if the plan provides benefits for this). This waiting period may be credited or waived based on prior healthcare coverage.

4) I understand that this plan will not provide benefits for organ and bone marrow transplants for a period of 12 months from the effective date of my coverage. This waiting period may be credited or waived based on prior health care coverage.

5) I understand that no benefits are available under this plan for services or supplies related to an inpatient confinement that began prior to the effective date of coverage, unless the applicant is an "eligible individual" as defined by Federal law.

6) I understand that acceptance for coverage is dependent on: a) Persons listed on this application must be residents of the state of Washington in order to apply for and maintain coverage under this plan; and b) No one listed on this application is 65 years of age or older and eligible for Medicare on the date coverage would begin. "Resident" means a person who lives in the state of Washington, and intends to live in the state permanently or indefinitely. In no event will coverage be extended to an applicant who resides here for the primary purpose of obtaining healthcare coverage. The confinement of a person in a nursing home, hospital or other medical institution shall not by itself be sufficient to qualify such person as a resident. LifeWise may require proof of residency from time to time. Such proof shall include, but not be limited to, the street address of the individual's residence and not a post office box.

7) I understand and agree that only LifeWise may: a) Make or modify the terms of the application or contract; or b) Waive any of the LifeWise rights or requirements. I understand that I may receive benefits which are less than the amount billed by my provider when treatment is not received from a contracted provider.

8) I understand and agree that this coverage is issued as individual health coverage, is not sold or issued for use as a government, or third party sponsored health plan, and is not partially or fully paid for by a government agency or third party payer, either directly or indirectly, except as required by law.

11 Signatures

I hereby apply for enrollment with LifeWise for myself and family members listed on this application for coverage under the Individual contract indicated on this form. I understand I will have the right to examine and return the contract within 10 days of its delivery to me. I certify that:

a) I have read this form, agree to its terms and I have supplied all of the required information on this form.

b) I have received and read a product information packet containing plan summaries and understand that a complete list of exclusions and limitations is detailed in the contract. If there is a conflict, the terms of the contract prevail.

c) I declare that, to the best of my knowledge, all of the information on all forms necessary for enrollment is true and complete, and that all of the persons for whom I am requesting enrollment are eligible for coverage. I understand that, if I have made false, incomplete, or misleading statements or answers on behalf of myself or any family members, all entitlements to benefits are void and this contract may be cancelled or modified retroactively to its effective date. I further understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Approved applications postmarked or received by the 14th day of the month will be effective on the 15th of that month. A prorated subscription charge will apply for the partial month of coverage. Approved applications postmarked or received by the last day of the month will be effective on the first day of the following month. This does not apply to applicants enrolling during open enrollment.

☐ **Yes** ☐ **No** | If one or more family members are not accepted for coverage, I authorize LifeWise to enroll those who are eligible in the plan I have selected (not applicable to HSA plans if this would result in changing family coverage to individual coverage).

Important! Signatures are required for all applicants over the age of 18.

Signature of Primary Applicant (Parent/Legal Guardian) X	Date of Signature / /
Signature of Spouse/Domestic Partner X	Date of Signature / /
Signature of Dependent Child over age 18 X	Date of Signature / /
Signature of Dependent Child over age 18 X	Date of Signature / /

12 My final checklist:

Omissions or incomplete answers will result in the return of your application and may cause a delay in the effective date of your coverage.

Did I remember to:

☐ Choose an effective date in Section 3?

☐ Indicate in Section 4 whether my spouse/domestic partner or I use tobacco? This will ensure I pay the correct rate.

☐ Select only one deductible option in Section 5?

☐ Complete a Standard Health Questionnaire for each applicant over the age of 19 unless one of the criteria listed in Section 7 applies?

- ☐ If one of the criteria listed in Section 7 applies, did I attach evidence of my exemption qualification based on my selection in Section 7?

☐ Attach my Certificate of Coverage or other documentation as evidence of my prior coverage if I completed Section 9?

☐ Get all applicants over the age of 18 to sign this application in Section 11?

Mail completed application to:

LifeWise Health Plan of Washington
PO Box 91120, MS 295
Seattle, WA 98111-9220
1-800-592-6804 • lifewisewa.com

13 HIPAA Eligibility Requirements

If you meet all the requirements described below (excerpted from the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, 42 U.S.C. 300gg-41b), you may be considered an "eligible individual" for having waiting periods for pre-existing conditions and creditable coverage waived or credited.

- You have had 18 or more months of prior health care coverage, the most recent of which was through a group, governmental, or church health plan, with no lapse in coverage of more than 63 days.
- You are not eligible for Medicare or any other group coverage.
- You were not terminated from prior coverage due to nonpayment of premiums or fraud.
- You are either ineligible for COBRA or state continuation coverage, or if eligible, have exhausted that coverage.

14 Notice of Information Use and Disclosure

Type of Information to be Disclosed: I (We) authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my (our) personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders, mental illness to LifeWise or its representatives as allowed by law.

Purpose of Disclosure: I (We) understand that personal information will be used for underwriting, evaluating enrollment in the health plan, determining eligibility for benefits and paying claims.

Timeframe of Release: Unless I revoke it, this release will remain valid for twenty-four (24) months from the date of my signature below.

Revocation of Release: I understand that I may change my mind and revoke this release at any time. I will do this by letting LifeWise know of my decision. Any change will be effective five (5) business days after LifeWise receives my written notice at the address listed on this form. I understand that some or all of this information may already have been used by LifeWise to make decisions, which will not be affected by its revocation.

Redisclosure: LifeWise Health Plan of Washington may be required to redisclose this information to another party that is not subject to state and federal privacy rules.

Effect of Not Authorizing: This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you benefits.

Please Note: You or your authorized representative will receive a copy of this authorization.

Completion of this section BY THE PRODUCER is required if the producer wishes to be considered as producer of record for the applicant. All producer information must be provided below to ensure credit/commission for the application.

Agency Name Avenue Insurance Planners	
Producer Name Brian Gruss	LifeWise Producer Number 72915
Producer Address PO BOX 1483 Veradale, WA 99037	
Producer Telephone Number (509) 927-9200	Producer E-mail Address brian@briangruss.com
Producer Signature X	Date / /

Please Note: Producers who do not have a current appointment with LifeWise are not authorized to offer LifeWise products.

STANDARD HEALTH QUESTIONNAIRE FOR WASHINGTON STATE

Use for Individual Coverage Beginning On or After October 1, 2009
Revised for coverage beginning on or after June 10, 2010

Important Information Before You Start

- Washington law allows private health carriers to require a person applying for an individual policy to complete the attached Standard Health Questionnaire and requires persons applying for nonsubsidized enrollment in the Basic Health Plan to complete the questionnaire if they do not qualify for an exemption. For purposes of this questionnaire subsequent references to "health carrier" include the Health Care Authority when administering the nonsubsidized Basic Health Plan.
- Under some circumstances **you may be exempt from taking the questionnaire**. (See page 2.)
- The Standard Health Questionnaire was created by the Washington State Health Insurance Pool (WSHIP). It is the only health screening allowed by law for health carriers to use if they wish to screen for health conditions as a part of their determination of eligibility of people who apply for private, individual medical coverage.
- **Those rejected for medical coverage due to their score on the Standard Health Questionnaire are eligible for WSHIP coverage**. WSHIP was created by the Washington State Legislature to provide health coverage to those rejected for individual medical coverage or to those unable to obtain comprehensive coverage on either an individual or group basis.
- Health carriers may use the Standard Health Questionnaire as a health screening tool for products such as stand-alone prescription drug plans, disability income replacement or life insurance policies sold by the health carrier. Use of the Standard Health Questionnaire for these kinds of products does not guarantee the right to coverage with the Washington State Health Insurance Pool if an applicant is denied coverage for one of these products.
- The Standard Health Questionnaire is available from private health carriers on **paper** as a part of their application packet **or electronically for those applying for coverage on-line**.

Attention: If you are currently eligible for Medicare, or will be on the requested effective date of coverage for which you are applying, you are not eligible for private individual or family health coverage; and you should not fill out this questionnaire. **Medicare** is a federally sponsored program for individuals age 65 or older, or who have end-stage renal disease, or are disabled as defined by Social Security. Medicare and **Medicaid** are different. Medicaid is a state-sponsored program for individuals and families who qualify based on income and other criteria.

Need Help in Answering this Questionnaire?

- *Contact the **health carrier** that you are submitting your application to; or*
- *Contact your **insurance agent**; or if you do not have an agent, use the **WSHIP Agent Directory** to locate an agent who is knowledgeable about the questionnaire. Request a copy of the Agent list from the health carrier to whom you are applying, or go to **www.wship.org***

ARE YOU EXEMPT FROM TAKING THIS QUESTIONNAIRE?

Revised for coverage beginning on or after June 10, 2010

Answer the following questions before you fill out the questionnaire *to determine if you meet one of these exemptions.*

If you do not know the answer *to a question,* ***do not fill out this questionnaire****. Please contact your agent or health carrier to whom you are applying for further instructions.* You may be asked to provide further documentation to support your responses to the following questions.

If you answer "Yes" *to any of the following questions,* ***do not complete the health questionnaire.*** You may apply to the health carrier without taking the questionnaire.

If you answer "No" *to all of the following questions****, this page must be completed along with Parts 2 and 3 of the questionnaire.*** *Submit the completed questionnaire to the health carrier with your application.*

Question	Yes	No
1. **Have you changed residences from one part of Washington state to another part where your current health plan is not offered, and you are submitting your application within 90 days of relocation?**	○	○
2. **Is your health care provider no longer part of the provider network on your current individual health plan?** To answer yes, all of the following must be true: a. Your health care provider is on the new health plan you are applying for; and b. You received services from that provider during the 12 months before he or she left your current health plan; and c. You are submitting your application to the new health plan within 90 days of your provider leaving your current health plan's network.	○	○
3. **Are you applying for individual health coverage within 90 days of using up your COBRA* coverage?** (This includes loss of COBRA coverage due to your employer going out of business or discontinuing its health plan while you are on COBRA.) To answer yes, you must have used up your COBRA coverage for any reason other than misrepresentation, gross misconduct, or failure to pay your premium.	○	○
4. **Have you been covered by a group plan provided by an employer that is exempt from COBRA, and you are applying for individual health coverage within 90 days of an event which would qualify you for COBRA if your employer had not been exempt from COBRA, and you had at least 24 months of continuous group coverage prior to such event?**	○	○
5. **Are you applying for individual health coverage within 90 days of terminating your COBRA coverage and you had at least 24 months of continuous group coverage prior to termination?** (Not applicable to BHP applicants.)	○	○
6. **Are you applying for individual health coverage within 90 days of an event which qualifies you for COBRA, and you had at least 24 months of continuous group coverage prior to such event but you choose not to take COBRA coverage?** (Not applicable to BHP applicants.)	○	○
7. **Have you been enrolled in the Washington State Basic Health Plan for at least 24 continuous months, and you are submitting your application within 90 days of disenrollment?**	○	○
8. **Are you adding coverage to your existing individual policy for your newborn or adopted child who has been born or placed for adoption with you within the last 60 days?**	○	○
9. **Are you applying for individual insurance 90 days before or after your employer discontinues your group insurance due to business closure and you had at least 24 months of continuous group insurance coverage immediately prior to your insurance being discontinued and the effective date of the individual insurance you are applying for is on or within 90 days after the date your group insurance is discontinued?**	○	○

* COBRA refers to the federal law that requires certain employers to continue health coverage temporarily for certain former employees, retirees, spouses and dependents, at their expense when coverage is lost due to certain specific events. For more information about COBRA rules, go to the U.S. Dept. of Labor website: http://www.dol.gov/ebsa/faqs

PART 1.
INFORMATION ABOUT THE STANDARD HEALTH QUESTIONNAIRE

Submitting Your Questionnaire

- If you are applying for family coverage, **a separate questionnaire must be completed for each family member**.
- **Do not send medical records with this questionnaire**. If you are rejected for coverage and appeal the rejection, the health carrier may request further medical information which you may choose to provide if you believe it will assist the carrier in correctly scoring your questionnaire.
- If you have had health coverage from the health carrier to whom you are now applying for individual coverage, as part of reviewing your questionnaire the health carrier may also review the medical information in its files dating from your prior coverage with the health carrier.
- Any time you apply for individual coverage, change from one health carrier to another, or change plans with your current health carrier, a current health questionnaire may be required unless you are exempt from taking the questionnaire (see exemptions list page 2).
- **Your signed questionnaire will be valid to accompany your application for coverage for a 90 day period from the date you sign it**. If you wait more than 90 days to submit your application, you may have to complete a new health questionnaire.

How Your Questionnaire Is Scored

- The health carrier uses a standard scoring system designed by WSHIP to score your questionnaire.
- The scoring system document can be obtained from your health carrier or agent, or viewed and printed from WSHIP's website, www.wship.org.
- **Questions about the scoring of your questionnaire must be directed to the health carrier you are applying with, or your insurance agent, but <u>not</u> to WSHIP**.

If You Are Denied Coverage Because of Your Score

- If the health carrier rejects your application because of your score **you must be sent a rejection notice within 15 business days** after the health carrier **received** your completed application and health questionnaire. To be "complete" this questionnaire must be signed and dated. You must fully and completely answer every question.
- The health carrier will mail you information about coverage available through WSHIP. Your insurance agent can also provide this information to you, or you can contact WSHIP toll-free at 1-800-877-5187, or at www.wship.org. **To be eligible for WSHIP you must apply for coverage within 90 days of the date you receive your notice of rejection from the health carrier**.
- You may request an appeal of your score.

How To Appeal Your Score To the Health Carrier

You may request a review of your score if you think the health carrier did not score your questionnaire correctly or did not respond within the required time frame.

- To request a review of your score, **contact the health carrier directly in writing within 45 days of receipt of your rejection notice. Do not contact WSHIP to appeal your score.**
- **You may apply for coverage with WSHIP** during the time that your appeal is under review. (Contact WSHIP at 1-800-877-5187 for assistance.)

How To Appeal Your Score To WSHIP

- If the health carrier does not complete its review of your appeal within 30 calendar days of their receipt of your appeal request, or if you have exhausted your appeal rights with the health carrier, you may request a review from WSHIP.
- **WSHIP's review is limited** to whether the health carrier correctly applied the scoring system for the questionnaire and whether the health carrier's notice of rejection for coverage was provided or postmarked within 15 business days of the health carrier's receipt of your completed application.
- Send your written request for review to WSHIP along with:
    1. A copy of your completed health questionnaire;
    2. The health carrier's score of your questionnaire;
    3. A copy of your written appeal request to the health carrier; and
    4. A copy of the health carrier's written denial of your appeal, if applicable.
- **Mail to**: Appeals, WSHIP, P.O. Box 1090, Great Bend, KS 67530. For assistance call WSHIP toll-free at 1-800-877-5187.
- Within five business days of receipt of your request, WSHIP will respond to you confirming receipt of your request, the date it was received, the nature of the complaint and the resolution requested.
- WSHIP will investigate your appeal and make its decision within 30 days of receipt of the complete information needed to respond to the appeal. WSHIP will notify you and the health carrier of its decision. If you do not agree with the results of this appeal, you may appeal to the WSHIP Grievance Committee.
- **Contact WSHIP if you wish to enroll with WSHIP during your appeal review period.**

Your Privacy Rights

By completing this form, you are giving your medical information to the health carrier. Under Washington State RCW 48.43.021, except as otherwise required by statute or rule, a health carrier and the Washington State Health Insurance Pool (WSHIP), and persons acting at the direction of or on behalf of a health carrier or WSHIP, shall not disclose an applicant's personally identifiable health information unless such disclosure is explicitly authorized in writing by the person who is the subject of the information. Each health carrier issues its own "consumer privacy statement" and maintains its own privacy policies.

PART 2. QUESTIONNAIRE

Instructions

1. ***Fill in your name*** *and other information in the box below.*
2. ***Read the definitions*** *(next page) to help you understand the questions.*
3. *In each section,* ***answer the YES/NO question in the box at the top of the page*** *to the best of your ability. Review the conditions in the table below the YES/NO question before answering.*
4. ***If you answer NO, you can move on to the next section****.*
5. ***If you answer YES, fill in the circle(s) next to each numbered medical condition you have or had within the stated time period.*** *Mark all conditions you have or had. This includes any conditions which resulted from another primary diagnosis. For example, for cancers that have metastasized, mark all types of cancer for which you have been diagnosed, treated, medicated and/or monitored. If you have multiple instances of a single condition you only need to mark it once.*
6. ***If you do not find your condition*** *listed on the questionnaire,* ***you can search for it on WSHIP's website****, under the link "Guide to Marking Medical Conditions on the Standard Health Questionnaire"* ***or you can write down this condition in Section L*** *of the questionnaire. Some rare medical conditions are not included in the questionnaire; however, they may be scored. A list of rare conditions can be obtained from the health carrier you are applying to or from the Office of Rare Disease Research* http://rarediseases.info.nih.gov/RareDiseaseList.aspx*; or from WSHIP's website, www.wship.org.*
7. *In answering this questionnaire, you are protected by federal law from having to reveal any information about your family history or any experience with genetic testing, genetic counseling, or other genetic services not related to diseases you currently have.*
8. *If you are the* ***parent or guardian*** *who is filling out this questionnaire for a child or individual with disabilities, please answer the questions as if "you" means the child or disabled individual; and check the box at the bottom of the signature page.*
9. ***Sign*** *and write the* ***date signed*** *on the last page.*

IMPORTANT: *Do not say you have a condition* ***unless*** *a doctor or other licensed medical care provider told you that you have or had a condition.* ***Be sure to mark all of the conditions you have or had****.*

Your height and weight will be used in scoring to determine if you have morbid obesity.

ABOUT YOU – YOU MUST FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF:

First Name M.I. Last Name

Date of Birth / / Contact Phone Number ( ) –

Height: Feet Inches Weight: Pounds

Mailing Address City State Zip

Email Address (optional, if you wish us to use it to contact you)

Gender ○ Male ○ Female

Definitions

The following is a **list of terms** used in this questionnaire. These definitions will help you fill out the questionnaire if you do not understand any terms used.

- **Acute** (as opposed to **Chronic**)**:** An illness typically with a sudden onset and resolving after a single course of treatment or therapy. Many are infectious in origin. Examples include pneumonia, gastritis, urinary tract infection, and minor trauma not requiring surgery.

- **Benign** (as opposed to **Malignant**)**:** A mild and non-progressive form of a disease.

- **Chronic** (as opposed to **Acute**)**:** A continuing illness that may or may not improve over time. Chronic illnesses can last from weeks to years. Examples include heart failure, COPD, leukemia, and many of the psychiatric illnesses such as depression and schizophrenia.

- **Congenital:** A condition that existed at birth. This condition may be inherited or may have developed in the womb. Although the condition existed at birth it may not be discovered until later in life.

- **Diagnosed:** A licensed physician or medical professional has identified a specific disease or medical condition.

- **Malignant** (as opposed to **Benign**)**:** A severe and progressively worsening form of a disease.

- **Medicated:** A drug prescribed by a licensed physician or other licensed medical professional has been taken for the treatment of a medical (including mental) condition.

- **Monitored:** A licensed medical professional has assessed the state of an existing or previously diagnosed disease or condition, possibly including diagnostic tests or imaging. A specific condition must first be diagnosed to be monitored. Monitoring does not include routine preventive screenings that are recommended for the general population in the absence of disease such as annual mammograms for women.

- **Physical Trauma:** An injury to any tissue by physical or chemical means. This may include abrasions, lacerations, incisions, or stab, puncture, or bullet wounds. When trauma occurs to the bone, this can result in fractures, dislocations, or sprains. Trauma can also be the result of exposure to toxic chemicals, high heat, irradiation, or electrical shock causing damage to tissues and organs.

- **Treated:** A licensed physician or other licensed medical professional has recommended a course of action or performed services to remedy a disease. For example, having surgery and having a diet and exercise program developed by a physician are both forms of treatment.

Section A. Certain High-Scoring Medical Conditions

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the last 5 years? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) within the last 5 years.*

○ No *If NO, complete Sections B through L.*

Section A. Certain High-Scoring Medical Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had) in the last 5 years*
1	AIDS	○
2	HIV sero-positive without AIDS	○
3	Amyotrophic lateral sclerosis (Lou Gehrig's disease)	○
4	Autism - Severe: minimal and inappropriate interaction with others, repetitive or restrictive behaviors (hand flapping, head rolling, self injury), limited or no speech, frequently requiring placement into a special education setting	○
5	Bilateral (left and right) leg amputation	○
6	Biliary atresia (congenital blockage of bile duct)	○
7	Brain or spinal cord abscess	○
8	Brain injury resulting in a deep or prolonged coma	○
9	Central nervous system (brain or spinal cord) malformation prior to birth (prenatal in origin)	○
10	Cerebral palsy	○
11	Cervical spina bifida	○
12	Cirrhosis of the liver	○
13	Cretinism	○
14	Cystic fibrosis	○
15	Fetal damage resulting from medication or substance usage (example: fetal alcohol syndrome)	○
16	Fragile X syndrome	○
17	Hemophilia	○
18	Huntington's Chorea	○
19	Inflammatory bowel disease (e.g. Crohn's disease, ulcerative colitis)	○
20	Leukemia	○
21	Lymphoma (examples: Hodgkin's disease, multiple myeloma, non-Hodgkin's lymphoma, reticulosarcoma)	○
22	MRSA (methicillin resistant staph) infection of internal organs other than the lungs	○

TABLE CONTINUED ON NEXT PAGE

Section A. Certain High-Scoring Medical Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had) in the last 5 years*
23	Mucopolysaccharidoses (example: Hunter's syndrome)	○
24	Multiple sclerosis	○
25	Muscular Dystrophies (examples: Duchenne, Pompe)	○
26	Myelodysplastic syndromes (examples: pancytopenia, aplastic anemia)	○
27	Necrotizing fasciitis (example: flesh eating bacterial infection)	○
28	Nephrotic syndrome	○
29	Organ transplant except cornea	○
30	Peritonitis (example: inflammation or infection of intestinal lining)	○
31	Pulmonary heart disease	○
32	Rheumatic heart disease – with complications (heart valve damage, anemia)	○
33	Severe Burns on more than 50% of one's body	○
34	Spinal trauma **with** surgery completed or recommended in the future or **with** paralysis (examples: fracture of the lumbar vertebrae, closed fracture of dorsal vertebra)	○
35	Subdural hematoma (blood clot on the brain) – **with** complications (loss of speech, sight, memory; paralysis)	○
36	Wegener's granulomatosis	○

- *If you answered YES to Section A, you may choose to answer each Section B through L, or you may skip to Part 3.*
- *If you answered NO to Section A, complete Sections B through L.*

Section B. Cancer or Benign Tumors

Cancer (malignancy) develops when cells in a part of the body begin to grow out of control. Although there are many kinds of cancer, they all start because of out-of-control growth of abnormal cells. Sometimes these cells form tumors, which are abnormal growths of body tissues. Not all tumors are cancerous. **Benign tumors can also be referred to as cysts, polyps, or dysplasia.**

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section B. Cancer or Benign Tumor(s):			
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *For cancer, mark all sites including secondary cancers (metastasis).*		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
37	Adrenal – cancer		○
38	Bone and connective tissue – cancer (examples: bone metastases, gastrointestinal stromal tumors, leg sarcoma)		○
39	Bone and connective tissue – benign tumor (example: foot cyst)	○	
40	Breast – cancer **with** chemotherapy or radiation therapy completed or recommended in the future (examples: ductal carcinoma in situ (DCIS), lobular carcinoma in situ (LCIS))		○
41	Breast – cancer **without** chemotherapy or radiation therapy completed or recommended		○
42	Breast – benign tumor (examples: breast calcium deposits, breast duct papilloma, breast fibrocystic disease, breast fibroids, gynecomastia)	○	
43	Central nervous system – cancer, primary (examples: brain cancer, spinal cord cancer)		○
44	Central nervous system – cancer metastases (secondary cancer)		○
45	Central nervous system – benign tumor (examples: acoustic neuroma, benign meningioma, pineal gland cyst)		○
46	Ear/nose/throat/mouth – cancer (examples: cancer of the mouth, larynx cancer, pharynx cancer)		○
47	Ear/nose/throat/mouth – benign tumor (example: nasal polyp)	○	
48	Eye, external – cancer (examples: canthus cancer, carcinoma of the eyelid)	○	
49	Eye, external – benign tumor	○	
50	Eye, internal – cancer		○
51	Female reproductive system (uterus, cervix, or ovaries) – cancer **with** chemotherapy or radiation therapy completed or recommended in the future		○
52	Female reproductive system (uterus, cervix, or ovaries) – cancer **without** chemotherapy or radiation therapy completed or recommended		○
53	Female reproductive system (uterus, cervix, or ovaries) – benign tumor (examples: cervical dysplasia, endometrial hyperplasia, uterine fibroid)	○	
54	Genitourinary – cancer except prostate **with** chemotherapy or radiation therapy completed or recommended in the future (examples: bladder cancer, kidney cancer, renal carcinoma, testicular cancer)		○

TABLE CONTINUED ON NEXT PAGE

Section B. Cancer or Benign Tumor(s):			
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *For cancer, mark all sites including secondary cancers (metastasis).*		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
55	Genitourinary – cancer except prostate **without** chemotherapy or radiation therapy completed or recommended		○
56	Intestinal or rectal cancer – cancer (examples: carcinoid tumor, colon cancer)		○
57	Liver – cancer including liver metastases		○
58	Pancreas – cancer		○
59	Peripheral nerve – cancer (example: neurofibromatosis)		○
60	Pituitary gland – cancer		○
61	Pituitary gland – benign tumor **with** acromegaly (gigantism), pituitary dwarfism, or diabetes insipidus		○
62	Pituitary gland – other benign tumors (examples: high prolactin levels, hyperprolactinemia, prolactinoma)		○
63	Prostate – cancer **with** chemotherapy or radiation therapy completed or recommended in the future		○
64	Prostate – cancer **without** chemotherapy or radiation therapy completed or recommended		○
65	Prostate – benign tumor (example: benign prostatic hypertrophy and/or hyperplasia (BPH))		○
66	Pulmonary system – cancer (examples: lung and bronchial cancer, lung metastases)		○
67	Pulmonary system – benign tumor (example: lung cyst)		○
68	Skin – cancer **with** chemotherapy or radiation therapy completed or recommended in the future (example: melanoma)		○
69	Skin – cancer **without** chemotherapy or radiation therapy completed or recommended		○
70	Stomach and esophageal – cancer		○
71	Thyroid and parathyroid – cancer		○
72	Other benign tumors (examples: abdomen, adrenal gland, anus, back cyst, basal cell growth, colon polyp, cystadenoma of the pancreas, esophagus, eye-internal, fatty tumor, genitourinary system, hyperplastic polyp, intestines, perianal cyst, parotid gland, pseudopapillary tumor of the pancreas, rectum, rectal cyst, seborrheic keratosis, skin, Zollinger-Ellison syndrome)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section C. Circulatory, Blood or Heart Conditions

Our vascular system is made up of blood vessels, which are part of our circulatory or cardiovascular system that works with the beating heart. With each beat, the heart pumps blood into the vessels and throughout the body, providing nutrients and oxygen to cells. The circulating blood removes waste products, toxins and other harmful substances. Our circulatory system is critical to many body functions, especially our respiratory or lung function, digestion, waste removal and body temperature. Medical conditions can occur when these systems are not working properly.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section C. Circulatory, Blood or Heart Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
73	Agranulocytosis (examples: leukocytopenia, neutropenia)		○
74	Anemia of chronic diseases (anemia with a chronic disease such as diabetes or kidney failure) (mark chronic disease as well)		○
75	Anemia – iron deficiency	○	
76	Anemia – sickle-cell		○
77	Aortic aneurysm (balloon-like weakened area) (example: stomach aortic aneurysm)		○
78	Arterial aneurysm, except aorta (example: subclavian arterial aneurysm)	○	
79	Arterial diseases – non-inflammatory (examples: abnormal connections between arteries and veins, abnormal narrowing of the arteries, fistulas, hereditary hemorrhagic telangiectasia, renal hyperplasia)	○	
80	Atherosclerosis (hardening of the arteries due to a build up of plaques)		○
81	Atrial fibrillation and flutter – **with** surgery completed or recommended in the future		○
82	Atrial fibrillation and flutter – **without** surgery completed or recommended		○
83	Cardiac – congenital disorders (examples: congenital heart block, congenital insufficiency of aortic valve, Ebstein's anomaly, ostium secundum type atrial septal defect, pulmonary stenosis, ventricular septal defect)		○
84	Cardiac – infection (examples: endocarditis, myocarditis, pericarditis)	○	
85	Cardiomyopathy		○
86	Conduction disorders – severe ventricular rhythms (examples: Long QT syndrome, ventricular fibrillation)		○
87	Conduction disorders – mild including severe heart block (examples: abnormal heartbeat – fast, slow or irregular heart rhythm, arrhythmia, atrioventricular (AV) block, bundle branch block, dysrhythmia, tachycardia, sick sinus syndrome)		○
88	Congestive heart failure		○

TABLE CONTINUED ON NEXT PAGE

Section C. Circulatory, Blood or Heart Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
89	Embolism (any substance that stops the flow of blood) or thrombosis (blood clot) of veins (examples: blood clots in the veins, deep vein thrombosis, venous stasis ulcers)	○	
90	Embolism – pulmonary	○	
91	Hematological diseases (examples: lymphadenitis, pernicious or other anemias, thalassemia)	○	
92	Hepatitis A or B (including viral hepatitis)		○
93	Hepatitis C		○
94	High blood pressure (hypertension) – benign		○
95	High blood pressure (hypertension) – malignant (hypertension resulting in damage to a major organs like the kidneys or eye) – **with** complications including kidney failure or congestive heart disease (mark complications as well)		○
96	High blood pressure (hypertension) – malignant (hypertension resulting in damage to a major organs like the kidneys or eye) – **without** complications		○
97	High cholesterol (examples: hyperlipidemia, hyperglyceridemia)		○
98	Ischemic heart disease – **with** angioplasty (balloon and/or stent), cardiac catheterization, or valve surgery (coronary artery bypass surgery or CABG) completed or recommended in the future (examples: angina, **coronary artery disease**, coronary atherosclerosis, **heart attack**, myocardial infarction, pectoris, ventricular hypertrophy)		○
99	Ischemic heart disease – **without** surgery completed or recommended		○
100	Lipidoses – unable to process fats (examples: Fabry's disease, Gaucher's disease, Krabbe disease, Mucolipidosis I-III, Niemann-Pick disease, Refsum's disease, Tay-Sachs disease, Wolman's disease)		○
101	Lymphatic channels disorders (example: noninfectious lymphedema)	○	
102	Thrombocytopenia (abnormally low platelets in blood)		○
103	Valvular disorder (examples: aortic valve disorders, mitral valve disorders)		○
104	Other circulatory conditions (examples: arteriovenous malformation, arteritis, inflammation of the veins, palpitations, phlebitis, Raynaud's syndrome, thrombophlebitis, varicocele, varicose veins, vasculitis, ventricular hypertrophy without ischemic heart disease)	○	
105	Other hematological conditions (examples: elevated white blood cell count not associated with infection, elevated red blood cell count, polycythemia vera)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section D. Digestive Conditions

When you eat, your body breaks food down to a form it can use to build and nourish cells and provide energy. This process is called digestion. Your digestive system is a series of hollow organs joined in a long, twisting tube. It runs from your mouth to your anus and includes your esophagus, stomach, and small and large intestines. Your liver, gallbladder and pancreas are also involved. They produce juices to help digestion. There are many types of digestive disorders and conditions. The symptoms vary widely depending on the problem.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section D. Digestive Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
106	Bowel obstruction/blockage (example: colonic volvulus)	○	
107	Diverticulitis (inflammation/infection of the colon)	○	
108	Esophagus – inflammation (examples: acid reflux disease, Barrett's esophagus, gastroesophageal reflux disease, GERD)	○	
109	Gall stones (cholelithiasis)	○	
110	Gastritis (inflammation/infection of the stomach) and/or duodenitis (small intestine)	○	
111	Hemorrhoids – **with** surgery completed or recommended in the future	○	
112	Hernia, hiatal	○	
113	Hernia, inguinal, ventral, or umbilical	○	
114	Hernia, other – **without** surgery completed or recommended (example: incisional hernia)	○	
115	Intestines and abdomen – congenital anomalies (examples: congenital obstructions and occlusions, Hirschsprung's disease, Meckel's diverticulum, prune belly syndrome)		○
116	Intestines and abdomen – inflammation (examples: mesenteric adenitis, peritoneal abscess)		○
117	Intestines and abdomen – trauma (examples: foreign body in intestine and colon, physical trauma)	○	
118	Intestines and abdomen – vascular diseases (examples: intestinal ischemia, mesenteric infarction, reduced blood supply to the intestines)	○	
119	Irritable Bowel syndrome (IBS)	○	
120	Pancreatitis (inflammation/infection of the pancreas) – acute	○	
121	Pancreatitis (inflammation/infection of the pancreas) – chronic or ongoing		○
122	Rectum or anus infection – **with** surgery completed or recommended in the future (examples: abscess or ulcer)	○	
123	Rectum or anus infection – **without** surgery completed or recommended	○	

TABLE CONTINUED ON NEXT PAGE

Section D. Digestive Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
124	Rectum or anus inflammation – **with** surgery completed or recommended in the future (examples: anal fistula, rectal prolapse)		○
125	Stomach or esophagus – anomaly (examples: congenital hernia, gastroparesis)	○	
126	Stomach ulcer (example: peptic ulcer)	○	
127	Other gastroenterological conditions (examples: abdominal pain, diarrheal infection if treated by a physician, hemorrhoids **without** surgery completed or recommended, other hernia **with** surgery completed or recommended, rectum or anus inflammation **without** surgery completed or recommended)	○	
128	Other hepatic and biliary conditions (examples: fatty liver disease, jaundice not of newborn, Non-Alcoholic Steatohepatitis (NASH), splenomegaly - enlarged spleen, toxic or non-infectious hepatitis)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section E. Endocrine, Lymphatic or Metabolic Conditions

The foundations of the endocrine system are the hormones and glands. As the body's chemical messengers, hormones transfer information and instructions from one set of cells to another. Too much or too little of any hormone can be harmful to your body. The lymphatic system clears away infection and keeps your body fluids in balance. Lymph vessels, which are different from blood vessels, carry fluid called lymph throughout your body. If your lymphatic system is not working properly, fluid builds in your tissues and causes swelling. Other lymphatic system problems can include infections, blockage, and cancer. Metabolism is the process your body uses to get or make energy from the food you eat. Chemicals in your digestive system break the food parts down into sugars and acids, your body's fuel. A metabolic disorder occurs when abnormal chemical reactions in your body disrupt this process.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section E. Endocrine, Lymphatic or Metabolic Conditions:		*Fill in the circle for each condition you have (or had)*	
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*In the **last 12 months**?*	*In the **last 5 years**?*
129	Adrenal gland hyper-functioning (examples: adrenogenital disorders, Bartter's syndrome, Cushing's syndrome)		○
130	Diabetes Type II – **with** other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac, hypertension) (mark other conditions separately)		○
131	Diabetes Type II – **without** other health conditions		○
132	Diabetes Type I – **with** other health conditions (renal/kidney, neurological/nerves, eye including the retina, cardiac, hypertension) (mark other conditions separately)		○
133	Diabetes Type I – **without** other health conditions		○
134	Nutritional deficiency (examples: malnutrition, Rickets, vitamin deficiencies)	○	
135	Thyroid gland conditions (examples: hypo- or hyper-functioning thyroid, congenital hypothyroidism)		○
136	Other diseases of endocrine glands (examples: carcinoid syndrome, congenital anomalies of other endocrine glands, precocious sexual development and puberty, Waldenström's macroglobulinemia)	○	
137	Other endocrinological conditions (examples: goiter, gout, hyper- or hypo-functioning parathyroid, hypogonadism)	○	
138	Other metabolic disorders (examples: cystinosis, disorders of iron metabolism, metabolic syndrome X, hypercalcemia, hyperkalemia, hyperpotassemia, hyponatremia, hypopotassemia, hyposmolality, monoclonal gammopathy, phenylketonuria (PKU), porphyria, xanthogranuloma)		○

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section F. Muscle, Skeletal or Skin Conditions

Musculoskeletal conditions comprise over one hundred diseases and syndromes, which are usually progressive, associated with pain, and involve your muscles, joints and bones. The largest organ in the body, the skin, is the first line of defense against dirt, germs and other foreign objects. Most skin disorders display symptoms on the surface of the skin.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section F. Muscle, Skeletal or Skin Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
139	Arthritis – adult rheumatoid		○
140	Arthritis – juvenile rheumatoid (under 17 years of age)		○
141	Autoimmune rheumatologic diseases except lupus and psoriasis (examples: ankylosing spondylitis, polymyositis, scleroderma, sicca syndrome, Sjörgen's syndrome)		○
142	Lupus		○
143	Psoriasis **with** arthritis		○
144	Bone and joint infection (example: osteomyelitis)	○	
145	Bursitis and tendonitis (not resulting in a loss of mobility)	○	
146	Joint and other soft tissue (tendons, muscles, cartilage, ligaments) – inflammation major (examples: costochondritis, fibromyalgia, inflammatory arthritis, lateral epicondylitis, myositis, osteochondritis dissecans, reflex neuromuscular dystrophy, tennis elbow)		○
147	Joint degeneration **with** surgery completed or recommended in the future (examples: ankylosis, degeneration of lumbar disc, degenerative arthritis, herniated disc, Osgood-Schlatter disease, osteoarthritis, osteochondropathy, pars defect, Perthes disease, sciatica, spinal stenosis, spondylosis)		○
148	Joint degeneration **without** surgery completed or recommended		○
149	Joint derangement (examples: chondromalacia, knee cartilage tears, dislocated joints, non-traumatic tendon ruptures, palindromic arthritis, torn meniscus)	○	
150	Orthopedic deformity (examples: Beal's syndrome, bunions, club foot, Crouzon's syndrome, Ehlers-Danlos syndrome, flat foot, ganglion, hammer toe, hip dysplasia, Marfan's syndrome, metatarsus varus, polydactyly, scoliosis, syndactyly, hip abscess)		○
151	Osteoporosis		○
152	Skin ulcers – chronic		○
153	Other orthopedic conditions (examples: lumbago, Profichet's disease, trigger finger, turf toe)	○	

TABLE CONTINUED ON NEXT PAGE

Section F. Muscle, Skeletal or Skin Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
154	Other skin conditions if treated by a physician (examples: acne, allergic skin reactions, boils, cellulitis, contact dermatitis, dermatomyositis, eczema, fasciitis pemphigus, fungal infections, morphea, pilonidal cyst, psoriasis **without** arthritis, rashes, rosacea, sebaceous cyst, skin abscesses, viral warts, vitiligo) – **NOT** MRSA or necrotizing fasciitis	○	
155	Other trauma (examples: ACL tears, amputations except bilateral leg, broken bones, burns including chemical burns covering less than 50% of the body, open wounds if treated by a physician, ruptured spleen, sprains, traumatic tendon ruptures, whiplash)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section G. Non-Psychiatric Conditions of the Nervous System

The nervous system is a complex, sophisticated system that regulates and coordinates body activities. Disorders of the nervous system may include the following: vascular disorders (such as stroke), infections (such as meningitis), structural disorders (such as brain or spinal cord injury), functional disorders (such as headache, epilepsy) and degeneration (such as Parkinson's disease, multiple sclerosis and Alzheimer's disease) are all examples of these disorders or conditions.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section G. Non-Psychiatric Conditions of the Nervous System:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
156	Brain trauma (examples: concussion, subdural hemorrhage **without** complications)	○	
157	Central nervous system – congenital disorders (examples: encephalopathy, essential tremor, Joubert syndrome, microcephaly) **NOT** Alzheimer's disease, ALS, or Parkinson's disease		○
158	Central nervous system – hereditary and degenerative diseases (examples: extrapyramidal disease and abnormal movement disorder, monomelic amyotrophy, myoclonus, obstructive hydrocephalus, spinal amyotrophy, syringomyelia, visceral myopathy)		○
159	Central nervous system – inflammation (examples: demyelinating disease of central nervous system, idiopathic peripheral autonomic neuropathy, paralytic strabismus, pseudotumor cerebri, vertigo of central origin)		○
160	Cerebral vascular accident (examples: brain bleed, cerebral atherosclerosis, cerebral autosomal dominant arteriopathy with subcortical infarcts and leukoencephalopathy (CADASIL), moyamoya disease, **stroke**, transient cerebral ischemia, transient ischemic attack (**TIA**), transient global amnesia)		○
161	Epilepsy		○
162	Meningitis (inflammation/infection of the lining of the brain and spinal cord)	○	
163	Migraine headache	○	
164	Nerves – carpal tunnel syndrome	○	
165	Nerves – traumatic disorders	○	
166	Nerves, cranial inflammation (affecting the head, face, eyes, tongue and/or throat including speech) (examples: atypical face pain, Bell's palsy, trigeminal neuralgia)	○	
167	Nerves, non-cranial inflammation – except carpal tunnel (examples: brachial plexus lesion, causalgia, Guillain Barre syndrome, meralgia paresthetica, myasthenia gravis, nerve lesions, neuralgia, neuralgic amyotrophy, neuritis, radiculitis, root lesions)	○	
168	Nerves, peripheral – congenital disorders (examples: idiopathic peripheral neuropathy, idiopathic progressive polyneuropathy)		○
169	Parkinson’s disease		○

TABLE CONTINUED ON NEXT PAGE

Section G. Non-Psychiatric Conditions of the Nervous System:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
170	Spinal trauma **without** paralysis or surgery completed or recommended (example: dislocated vertebrae)	○	
171	Other neurological conditions (examples: Alzheimer's disease, convulsions, dementia, isolated seizure, myelitis)		○
172	Other neurological diseases (examples: encephalitis, idiopathic hypersomnia, insomnia, narcolepsy, reaction to spinal or lumbar puncture, restless leg syndrome, verbal apraxia)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section H. Psychiatric (Mental Health) Conditions

Mental illness is any disease or condition affecting the brain that influences the way a person thinks, feels, behaves and/or relates to others and to his or her surroundings. Although the symptoms of mental illness can vary from mild to severe and are different depending on the type of mental illness, a person with an untreated mental illness often is unable to cope with life's daily routines and demands.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section H. Psychiatric (Mental Health) Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		In the ***last 12 months****?*	*In the* ***last 5 years****?*
173	Mood disorder - bipolar (example: cyclothymic disorder)		○
174	Mood disorder - depression (example: dysthymia)		○
175	Opioid or barbiturate dependence (examples: heroin, codeine, morphine, oxycodone dependence)		○
176	Psychotic and schizophrenic disorders (examples: hebephrenia, paranoia)		○
177	Other mental health conditions (examples: adjustment disorders, anxiety disorders, Asperger's syndrome, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), eating disorders, erectile dysfunction if mental, mild autism, panic disorders, phobias, post traumatic stress disorder, seasonal affective disorder)		○
178	Other substance abuse conditions (examples: acute alcohol intoxication requiring medical attention, alcoholism, amphetamine dependence, cannabis dependence, cocaine dependence)		○

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section I. Respiratory Conditions

The respiratory system consists of the airways, the lungs, and the respiratory muscles that control the movement of air in and out of the body. Within the lungs, molecules of oxygen and carbon dioxide are exchanged between the air we breathe and the blood. Respiratory disease includes problems that obstruct or restrict breathing and include breathing problems from infection, the environment, or other diseases.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section I. Respiratory Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
179	Acute respiratory distress syndrome	○	
180	Asthma (example: reactive airway disease)		○
181	Chronic obstructive pulmonary disease (examples: emphysema, obstructive chronic bronchitis)		○
182	Occupational and environmental pulmonary diseases (examples: asbestosis, black lung disease, bronchitis due to fumes and vapors, silicosis)		○
183	Pneumonia – fungal (example: aspergillosis)	○	
184	Other inflammatory lung diseases (examples: post inflammatory pulmonary fibrosis, sarcoidosis)		○
185	Other pulmonary conditions (examples: acute bronchitis, bacterial or viral pneumonia, congenital pulmonary conditions, flu if treated by a physician)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section J. Urinary, Genital, and Reproductive Conditions

Urinary conditions are comprised of problems with how the kidneys, ureters, bladder, and urethra function. The female reproductive system is made up of the vagina, womb (uterus), fallopian tubes and ovaries. The male reproductive system is made up of the penis, the testicles, the epididymis, the vas deferens and the prostate gland.

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section J. Urinary, Genital, and Reproductive Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
186	Endometriosis		○
187	Female genital system diseases (example: dyspareunia)	○	
188	Female sex gland disorders (examples: ovarian failure, polycystic ovaries)		○
189	Genitourinary system – inflammation including torsion of the testes (examples: hydrocele, spermatocele)	○	
190	Interstitial cystitis – chronic (examples: Hunner's ulcer, persistent inflammation of the bladder)	○	
191	Kidney infection	○	
192	Kidney or bladder stones	○	
193	Renal conditions (example: polycystic kidney)	○	
194	Renal failure – acute	○	
195	Renal failure – chronic		○
196	Renal inflammation – acute (example: IgA nephropathy)	○	
197	Renal inflammation – chronic (example: glomerulonephritis)		○
198	Other gynecologic conditions (examples: Bartholin's gland conditions, dysmenorrhea, hematometra, menopausal conditions, metrorrhagia, problems with menstruation, vaginal infection including yeast infections, vaginitis)	○	
199	Other nephritic conditions (examples: excess protein in urine, lesions in the kidneys)	○	
200	Other urologic conditions (examples: bladder infection, blood in the urine, epididymitis, erectile dysfunction if physical, hematoma of the kidney, gonorrhea, orchitis, prostatitis, sexually transmitted diseases infecting the genitals, trauma to the genitourinary system, urinary tract infection)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section K. Other Conditions

Have you been diagnosed, treated, medicated, and/or monitored for any of the conditions listed in the table below within the time frame specified? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes *If YES, fill in the circle next to the condition you have (or had) only if the applicable time frame applies to you.*

○ No *If NO, continue on to the next section.*

Section K. Other Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
201	Adverse environmental exposures (examples: angioedema, food allergies, heat stroke, electrocution – mark any burns from the electrocution separately)	○	
202	Chromosomal anomalies (examples: autosomal deletions, Cri du Chat syndrome, Down's syndrome, Edwards' syndrome, Klinefelter's syndrome, Patau's syndrome, Prader-Willi syndrome, Turner's syndrome, Velo Cardio Facial syndrome (VCFS)) **NOT** Fragile X syndrome		○
203	Eye – cataract		○
204	Eye – internal infection (examples: chorioretinitis, endophthalmitis, pars planitis, viral infections of the inner eye, vitreous abscess)	○	
205	Eye – glaucoma or other intra-occular hypertension		○
206	Eye – macular degeneration		○
207	Eye – retinopathy (example: diabetic retinopathy)		○
208	Immunodeficiencies – deficiency of humoral immunity (examples: common variable immunodeficiency, hypogammaglobulinemia)		○
209	Immunodeficiencies – other (example: Wiskott-Aldrich syndrome)		○
210	Mental retardation		○
211	Poisonings and toxic effects of drugs (examples: all drug reactions, venomous bites)	○	
212	Septicemia **with** septic shock	○	
213	Sexually transmitted diseases disseminated to other parts of the body (examples: chlamydia outside the genitals, Reiter's disease)	○	
214	Sinusitis – chronic (examples: more than 3 sinus infections in past 12 months, allergic sinus reactions, hay fever, chronic rhinitis)		○
215	Tuberculosis – pulmonary	○	
216	Tuberculosis – disseminated (tuberculosis spread to other organs beyond the lungs)		○
217	Other ear, nose, and throat conditions (examples: acute sinusitis, cochlear implants, ear infections, hearing disorders, hearing loss, nasal congestion if treated by a physician, sleep apnea, sore throat if treated by a physician, tinnitus, tonsillitis)	○	

TABLE CONTINUED ON NEXT PAGE

Section K. Other Conditions:			
For which conditions have you been diagnosed, treated, medicated, and/or monitored?		*Fill in the circle for each condition you have (or had)*	
		*In the **last 12 months**?*	*In the **last 5 years**?*
218	Other eye conditions except minor vision problems (nearsightedness, farsightedness) (examples: blepharitis, chalazion, conjunctivitis, drooping eyelids, eye wandering, injury to the cornea, lazy eye, macular edema, meibomitis, optic neuritis, pink eye, retinal tear, strabismus, stye)	○	
219	Other infectious diseases (examples: anthrax, chicken pox, cold sores, dengue fever, E. Coli infection, gangrene, herpes simplex, infectious mononucleosis, lyme disease, malaria, MRSA infecting the skin or lungs, parasitic infection, pertussis, rabies, septicemia **without** septic shock, shingles, small pox, staph infection, tetanus, viral infections, West Nile virus, Whipple's disease, whooping cough)	○	
220	Other neonatal conditions (examples: jaundice in newborns, croup)	○	

WHEN YOU ARE DONE WITH THIS TABLE GO TO THE NEXT PAGE

Section L. Write-in Conditions

Have you been diagnosed, treated, medicated, and/or monitored for other medical conditions in the last 5 years not listed in any previous Sections? *Only answer YES if a doctor or other licensed medical provider told you that you have or had this condition.*

○ Yes — *If YES, in the table provided below indicate which conditions and fill in the circle(s) for each applicable time frame that applies to you.*

○ No — *If NO, continue on to Part 3.*

Section L. Write-In Conditions:		
For which conditions have you been diagnosed, treated, medicated, and/or monitored? *List the name of the condition, not the procedure or drug used to treat the condition. For example list the cause of knee replacement not the knee replacement itself.*	*Fill in the circle for each condition you have (or had)*	
	*In the **last 12 months**?*	*In the **last 5 years**?*
	○	○
	○	○
	○	○
	○	○
	○	○
	○	○
	○	○

The scoring for certain write-in conditions can be viewed on WSHIP's website, under the link "Guide to Marking Medical Conditions on the Standard Health Questionnaire": www.wship.org

Note that certain rare conditions, even if not specifically listed in this document, may result in a score above the denial threshold. For these conditions to be scored above the threshold 1) it must be verified that the condition is rare by viewing the National Institute of Health's list of rare conditions at http://rarediseases.info.nih.gov/RareDiseaseList.aspx; and 2) the average annual health care cost of treating the condition must be shown to have an average annual cost above the threshold (8% most costly) set by statute. If further information is needed, please contact a carrier or agent.

The following conditions and information are not scored and do not need to be included:

- Any condition for which you have not sought licensed medical advice
- Coughs
- Dental conditions treated by a dentist
- Fevers
- General malaise or fatigue
- Information about your family history or any experience with genetic testing, genetic counseling, or other genetic services that are not related to diseases you have currently
- Minor joint pain treated with over the counter (OTC) medications and that have not been diagnosed by a specialist; this may be called arthritis but no determination of which kind of arthritis has been made
- Nearsightedness or farsightedness
- Pregnancy or pregnancy related conditions (gestational diabetes, varicose veins in pregnancy)
- Preventive or routine screenings without abnormal results

WHEN YOU ARE DONE WITH THIS TABLE PROCEED TO THE NEXT PAGE

PART 3. SIGNATURE AND SCORING PAGE

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following:**

1. **All of the information I have given is true and complete**.
2. I understand that if I leave an answer blank to an individual condition it is the same as a "No" answer.
3. If I answered "No" to Section A, I have completed all remaining Sections, B through L of Part 2, and indicated "Yes" or "No" at the top of each Section, B through L.
4. I understand that if I omit or give false information I may lose my coverage, in which case I may have to pay for services paid under that coverage.
5. **I understand that if I intentionally give false information, in addition to losing my coverage, I may incur additional legal liability.**

If you do not sign and date this questionnaire below, it will be returned to you and your application will be delayed. Your signed questionnaire will be valid for a 90-day period from the date you sign it. If you wait more than 90 days to submit your application, you will have to complete a new questionnaire. To be complete, the page 2 exemptions list and Parts 2 and 3 of your questionnaire must have been filled out.

Please print name, then sign and date in the space provided.

First Name | M.I. | Last Name

Signature | **Date Signed** __/__/____

If you are signing on behalf of an underage child, check: ☐ **Parent** ☐ **Legal Guardian**

THANK YOU FOR COMPLETING THE STANDARD HEALTH QUESTIONNAIRE

This questionnaire is updated periodically. In an effort to continually improve the questionnaire, we have included a brief survey on our website. If you would like to provide feedback on your experience filling out this questionnaire, please go to the following web address: www.wship.org/SHQsurvey. This brief survey is optional and has no effect on your score.

FOR HEALTH CARRIER USE ONLY. DO NOT MARK THIS SECTION.

Name of health carrier

Date Reviewed __/__/____ | Reviewer ID | Member SSN (optional)

	Condition #	Score		Condition #	Score		Condition #	Score
1.			5.			9.		
2.			6.			10.		
3.			7.			11.		
4.			8.			12.		

Total Score

○ Applicant Accepted ○ Applicant Denied