



**SUPPLEMENTAL QUESTIONNAIRE  
FOR GROUPS OF INDIVIDUALS OF 10 OR MORE**

**Directions for use of this Form:**

Please make sure that all of the information requested below is complete, true and accurate. If accepted for membership, any misstatements or omissions in this questionnaire may result in rescission of membership and/or the voiding of the Individual Member Contract and Handbook to the original effective date.

**Note:** Have the applicant answer the following questions for him or herself and each applicant applying for membership and sign in the space provided below. **All questions** on this form must be answered.

**Questionnaire:**

1. In the past five (5) years have you, or any applicant, been diagnosed with or received treatment for any of the following diseases or malignant disorders:

**Yes**    **No**

- |                          |                          |                       |
|--------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer                |
| <input type="checkbox"/> | <input type="checkbox"/> | Lymphoma and Leukemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Melanoma              |
| <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer           |
| <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis B or C      |

2. Are you, or any applicant, expecting the birth of a child for which you, (or any applicant) may have a duty to provide medical care?     Yes     No

3. Have you, or any applicant, ever tested positive for or been diagnosed as having:

**Yes**    **No**

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Human Immunodeficiency Virus (HIV)                                |
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS Related Complex (ARC)  |
| <input type="checkbox"/> | <input type="checkbox"/> | Acquired Immunodeficiency Syndrome (AIDS)                         |
| <input type="checkbox"/> | <input type="checkbox"/> | Any medical condition associated with one of the above infections |

4. Have you, or any applicant listed, ever been diagnosed with, or been treated for, any form of obesity?     Yes     No

Sign below