IOA Re
Employee Health Questionnaire

Employer Name:				
	Full Name	DOB	Height	Weight
Employee				
Spouse				
Child				
Child				
Child				

DECLINATION OF COVERAGE:
I waive coverage for: ☐ Myself & all Dependents ☐ Spouse ☐ Child(ren)
Reason for Waiving: ☐ Covered Elsewhere ☐ Other (Cost, Medicare, Etc.)

Please answer YES or No to the following questions.
For all yes answers please provide complete details and dates of service in the grid below.

☐ YES ☐ NO 1. Within the past 5 years, has anyone been hospitalized or had surgery or been advised that medical treatment, diagnostic testing, surgery or hospitalization is necessary?

☐ YES ☐ NO 2. Is anyone listed on this health statement currently unable to work due to injury or illness?

☐ YES ☐ NO 3. Is anyone listed currently pregnant (please provide due date and any complications?)

☐ YES ☐ NO 4. Is anyone listed currently taking prescription drugs (please listed medications?)

5. Has anyone listed been diagnosed or treated for the following conditions? Please mark either "YES or "NO".

a. AIDS/ARC/HIV or disorder of immune system ☐ YES ☐ NO
b. Cancer, anemia or tumor of any kind ☐ YES ☐ NO
c. Heart disorder of any kind ☐ YES ☐ NO
d. Circulatory or blood disorder ☐ YES ☐ NO
e. Diabetes ☐ YES ☐ NO
f. Emphysema/COPD or other lung disorder ☐ YES ☐ NO
g. Respiratory arrest or failure ☐ YES ☐ NO
h. Congenital anomaly/birth defect/premature birth ☐ YES ☐ NO
i. Lupus, Multiple Sclerosis or systemic disorder ☐ YES ☐ NO
j. Cerebral disorder (CP, CVA, Guillain-Barre, ALS) ☐ YES ☐ NO
k. Organ, bone marrow or stem cell transplantation ☐ YES ☐ NO
w. colitis, Crohn's, or any intestinal disorder ☐ YES ☐ NO
l. Hepatitis, Cirrhosis or other liver disorder ☐ YES ☐ NO
m. Spinal Cord Injury or disorder ☐ YES ☐ NO
n. Amputation or burns ☐ YES ☐ NO
o. Hemophilia or other coagulation disorder ☐ YES ☐ NO
p. Alcohol/Chemical/Drug dependency ☐ YES ☐ NO
q. Nervous/Mental/Depressive disorder ☐ YES ☐ NO
r. Neurological or seizure disorder ☐ YES ☐ NO
s. Osteo/Rheumatoid arthritis ☐ YES ☐ NO
t. Back or Knee disorder ☐ YES ☐ NO
u. Kidney disorder or renal failure ☐ YES ☐ NO
v. Cystic Fibrosis ☐ YES ☐ NO
x. Other Condition not listed ____________________ ☐ YES ☐ NO

Name of Person	Question	Nature of illness/injury	MO/YR	Duration	Complete Details/Explanation

Authorization: I agree all of the information listed above is complete, accurate and true. I understand misstating or omitting known information may constitute insurance fraud subject to punishment in accordance with applicable law. I authorize IOA Re, Inc. and their authorized representatives to obtain medical information in order to evaluate the information listed in this health statement. This authorization will expire 24 months from the date on this form or sooner if prescribed by law. Physician Name ________________________.

_______________________________________ ____________________
Signature of Employee Date