Physicians' Benefits Trust Life Insurance Company
Health History Questionnaire

This form must be completed for each applicant and dependent. Please complete all sections and write legibly so your application can be processed without delay. Questions left unanswered or incomplete may delay or prevent processing of your request for coverage.

Section 1

Name of Applicant: ____

Gender: □ F □ M Relationship to Primary Applicant: □ Self □ Spouse □ Child

Have you used tobacco products in the last 12 months? …………………………….□Yes □ No

Date of Birth: ____/____ /____ Height: _______ Weight: ____________________

Have any blood relatives died before age 65? …………………………………………. □Yes □ No

Cause of Death: _________________________ Relationship: ____________________________

Section 2: Applicant completes all of the following health questions. Any "Yes" answers (except to Question A) should be explained below. Please check the appropriate box(es).

A. Are you currently in good health and free from treatment for any condition	□ Yes □ No
B. Have you been diagnosed, or are you aware of, or are you currently pregnant	□ Yes □ No
C. Have you been disabled for more than a total of 15 days within the last 12 months?	□ Yes □ No
D. Have you been confined to a hospital, skilled nursing home, rehabilitation facility, or other medical care facility within the last 12 months?	□ Yes □ No
E. Within the last 3 years have you been advised by a medical professional to have, but have not yet had, surgery, treatment, examination, evaluation, or test for any medical condition?	□ Yes □ No
F. Have you ever been treated for, or been told that you had:	
1. High blood pressure, heart disease, stroke, hypertension, high cholesterol, heart attack, aneurysm, angioplasty, coronary bypass, hemophilia, or other disease of the circulatory system?	□ Yes □ No
2. Ulcer, appendicitis, hernia, Crohn's disease, colitis, kidney stones, renal failure, other kidney problems, gallstones, hepatitis, cirrhosis, other problems of the liver, acid reflux, GERD, or other disease of the digestive system?	□ Yes □ No
3. Tumors, malignant or benign, leukemia, or any other cancer?	□ Yes □ No
4. Prostate, menstrual disorder or other disease of the genitourinary system?	□ Yes □ No
5. Chronic respiratory problems, asthma, emphysema, chronic bronchitis, COPD, cystic fibrosis, or other disease of the respiratory system?	□ Yes □ No
6. Depression, neurosis, eating disorder, other mental and nervous disorders or alcohol or drug dependency?	□ Yes □ No

7. Autism, ADD, ADHD, Alzheimer's disease, multiple sclerosis, epilepsy, seizures, or other brain or neurological disorders?	□ Yes □ No
8. Arthritis, rheumatism, fractures, lupus, joint repair or replacement, back, spine or other musculoskeletal disorders?	□ Yes □ No
9. Diabetes or other metabolic or endocrine disorders?	□ Yes □ No
10. Disorder of the blood - Disorder of the blood includes: all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease).	□ Yes □ No
11. Have you ever been treated/diagnosed by a medical professional for AIDS, tested positive for HIV, immune system disorders or blood disorders?	□ Yes □ No
12. Skin or dermatological disorders such as acne, psoriasis, burns, skin cancer, keloids requiring plastic surgery?	□ Yes □ No
13. Disorder of the eyes (other than vision impairment), ears, nose, or throat?	□ Yes □ No
14. Down's Syndrome, cerebral palsy, or other congenital defects or development disorders?	□ Yes □ No
15. Impotence, sexually transmitted diseases, uterine fibroids, breast implants, abnormal pap test, endometriosis, or other reproductive or genital disorders?	□ Yes □ No
16. Cosmetic or reconstructive surgery or revisions within the last 5 years?	□ Yes □ No
17. Any other disorders, diseases, ailments or impairments?	□ Yes □ No

Please provide the information requested. You can attach a separate sheet if necessary. Be sure to sign and date.

Condition, Type of Treatment	Date	Name and Address of Physician and Hospital	Results (ongoing or degree of recovery)
Is the treatment described above continuing? □ Yes □ No		**Date treatment was no longer required:** ___________/_________________/____________	

G. Do you currently take medication(s)?.. □ Yes □ No

Please provide the information requested. You can attach a separate sheet if necessary. Be sure to sign and date.

Medication Name	Dosage	Dates Taken	Prescribing Physician
1.			
2.			
3.			
4.			

Section 3:

Name and Address of Primary Physician: ____
Date last seen by Physician: _______/________ /________
Reason for visit: ____

Section 4:

I agree that, to the best of my knowledge and belief, all statements and answers to the questions contained in this application are true. I agree that they will be a basis of the issuance of coverage.

By signing this form I authorize Physicians’ Benefits Trust Life Insurance Company to gather individually identifiable health information, including medical records (excluding psychotherapy notes), lab records, and prescription records from sources including but not limited to physicians, clinics, hospitals, pharmacy benefit managers, and health plans. This information will be used for the purpose of evaluating and underwriting my insurance application. This authorization is valid until the time I receive a final determination on my application for coverage. I may revoke this authorization by notifying Physicians’ Benefits Trust Life Insurance Company in writing. I understand that this information may be subject to re-disclosure, and once re-disclosed, may no longer be subject to federal rules governing privacy. I understand that signing this form is voluntary and that I need not sign it to assure eligibility.

Signature of Applicant: ____

Date: ____________/__________________/____________________

Signature of Dependent (if 18 years of age or older): ___________________________________

Date: ____________/__________________/____________________

Return your completed Health History Questionnaire to:
PBT Insurance Office
200 E. Randolph Street • 5th Floor
Chicago, IL 60601

If you have any questions:
Physicians and their office staff please call: **1-800-621-0748**
Dentists and their office staff please call: **1-866-898-0926**
You can also fax your questions to:
1-312-381-2795

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