



INSTRUCTIONS: Please print clearly and answer ALL questions on BOTH sides of this form.

SUBSCRIBER NAME (LAST)		(FIRST)		(MIDDLE)		
HOME PHONE ()	WORK PHONE ()	EMERGENCY PHONE ()	BIRTH DATE	MONTH	DAY	YEAR
SOCIAL SECURITY NUMBER	— —		MARITAL STATUS	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MARRIED	
ADDRESS (NUMBER & STREET)		(CITY)	(STATE)	(ZIP CODE)		
GROUP NAME (IF APPLICABLE)						
GROUP ADDRESS (NUMBER & STREET)		(CITY)	(STATE)	(ZIP CODE)		

List all persons to be covered. Attach additional sheets if necessary.

Member Letter	Full Name	Sex	Relationship to Subscriber	Birth date	Height	Weight	Social Security No.
A	Subscriber		Self				
B	Spouse		Spouse				
D	Dependents						
D							
E							
F							
G							

1. Instructions ▶ If the Subscriber/Family Member has consulted a doctor or has been advised by any doctor to have a surgical operation, diagnostic test or psychological care for any of the following (or any other condition/disease) within the fast five years, place the corresponding member letter assigned above in the column to the left of the condition.

Member letter	Condition	Member letter	Condition	Member letter	Condition	Member letter	Condition
	1. Alcoholism, drug abuse		9. Cancer. Type of cancer:		17. Foot problems or surgery; bunions or others		26. Skin rash, eczema or other disease of skin or nails for over three months
	2. AIDS Related Condition (ARC), Acquired Immune Deficiency Syndrome (AIDS)				18. Joint swelling pain, injury, arthritis, rheumatism, bone or joint problems		27. Stroke, paralysis, fainting or dizzy spells
	3. Asthma, hay fever, allergies		10. Circulation or heart problems; heart attacks		19. Kidney, bladder or urinary disease		28. Surgical operations
	4. Backaches, ruptured disc other back/spinal conditions		11. Diabetes (high blood sugar or sugar in urine), hypoglycemia (low blood sugar)		20. Liver or gall bladder problems, jaundice, hepatitis, cirrhosis or other		29. Thyroid or glandular problems, goiter, high or low metabolism
	5. Birth defects or disease, prematurity		12. Digestive conditions, ulcers, indigestion, rupture or hernia		21. Mental, nervous, psychiatric, psychological conditions		30. Varicose veins, phlebitis, blood clots in legs or elsewhere
	6. Blood disease, anemia, sickle cell, leukemia, other blood conditions		13. Ear conditions		22. Migraines or recurrent headaches		31. Tumors, lumps, or cysts (breast or others)
	7. Blood pressure problems, high (hypertension) or low blood pressure. If high or low, list usual blood pressure:		14. Emphysema, chronic cough, shortness of breath, lung problems		23. Muscular Dystrophy, Multiple Sclerosis, other nerve or muscle disease		32. Other injuries, deformities, disabilities
			15. Epilepsy, seizures, convulsions		24. Pregnant, complications with previous pregnancy		33. Other diseases or conditions:
	8. Bowel, intestinal or rectal problems; hemorrhoids, bleeding, colitis or others		16. Eye conditions		25. Reproductive organ conditions or surgery, male or female, including infertility problems		

You must also complete reverse side

