

INDIVIDUAL RISK EVALUATION FORM

(for groups with 2-25 eligible employees)



An Independent Licensee of the Blue Cross and Blue Shield Association

Employer Name: _____

Employee Name: _____
Last First Mi M F

Date of birth _____ Height _____ Weight _____
M F

Employee Social Security No.: _____

Employee Marital Status: Single Married

Spouse Name: _____
Last First Mi M F

Date of birth _____ Height _____ Weight _____
M F

Child Name: _____
Last First Mi M F

Date of birth _____ Height _____ Weight _____
M F

Child Name: _____
Last First Mi M F

Date of birth _____ Height _____ Weight _____
M F

Child Name: _____
Last First Mi M F

Date of birth _____ Height _____ Weight _____
M F

Have you or any member of your family enrolling for coverage been diagnosed, received treatment or are currently receiving treatment for any of the following conditions within the past 10 years (please complete each question):

- | | | | |
|---|--|---|--|
| 1. Cancer or tumor? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. Neurological conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 13. Have any claims over \$5,000 been billed in the last 18 months? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Alcohol/illicit drug use or abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Are there any ongoing disabilities? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Liver disease/Cirrhosis/Hepatitis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 15. Are you or your spouse/dependent currently pregnant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Lung or respiratory conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 16. Are you, or your spouse/dependent currently taking any medications? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Gall bladder, liver, stomach or intestines? | <input type="checkbox"/> Yes <input type="checkbox"/> No | 17. Have you, your spouse, or any dependent children been a patient in a hospital, clinic, surgi-center, sanatorium, urgent care facility, or other medical facility as an inpatient or outpatient? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Immune System? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 8. Psychological conditions? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 9. Heart conditions/hypertension/stroke? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 10. Bones/Joints/Muscles/Arthritis | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| 11. Kidney/Urinary tract/bladder (stones, infection)? | <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXPLANATION SECTION Explain any "Yes" below (attach additional sheets if necessary)					
Question#	Name/Age	Diagnosis Date	Diagnosis, Date Diagnosed and/or Medications (Name of medication, dosage, frequency, reason for taking/diagnosis)	Last Date of Treatment	Doctor's Name/Phone

Signature (This form must be signed)

I represent that, to the best of my knowledge, the information provided on this Risk Evaluation Form is complete and accurate. I understand that if I have misstated or omitted any information on this form, BCBSAZ may reassess premium applied to my employer group and/or me, or terminate BCBSAZ coverage in accordance with applicable law. BCBSAZ, its reinsurers, and their authorized representatives may obtain medical information in order to evaluate the information contained in this Risk Evaluation Form.

Employee Signature

Date Signed