DeanHealthPlan
A member of SSM Health

EMPLOYEE HEALTH HISTORY ADDENDUM

Dean Health Plan, Inc. • Dean Health Insurance, Inc.

P.O. Box 56099 • Madison, WI 53705 • 608-828-1301 • 800-279-1301

Please answer the following questions to the best of your knowledge.
Please provide the complete details if you answer "yes" to any of the questions below.

Employee Name: _____ Group Name: _____

			YES	NO
A		Are you, your spouse or any dependent child(ren) currently pregnant or an expectant parent? If "yes," due date is:	☐	☐
B		Has anyone named in this application been treated or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐
C		Has anyone named in this application used tobacco or smokeless tobacco during the past 12 months? If "yes," provide information as requested regarding the product, duration and frequency of use.	☐	☐
D		In the past five years, has anyone named in this application been evaluated or treated for alcoholism or chemical dependency; or joined any organization for alcoholism or chemical dependency; or used illegal drugs or been advised by a health care professional to reduce the use of alcohol or illegal drugs?	☐	☐
E		In the last ten years, has anyone named in this application been counseled, consulted or treated for any of the following (please check all conditions that apply):	☐	☐
	E1	Circulatory System including but not limited to: heart disease or disorder, stroke, circulatory disorder, chest pain, high or low blood pressure, elevated cholesterol and/or triglyceride levels, anemia or blood disorder.	☐	☐
	E2	Digestive System including but not limited to: ulcers, stomach disorder, liver disorder, pancreas disorder, gallbladder disorder, intestinal disorder, ulcerative colitis, Crohn's disease, hernia, rectal disorder?	☐	☐
	E3	Genitourinary System including but not limited to: menstrual disorder genital disorder, sexual dysfunction, pregnancy complications (premature birth, miscarriage, c-section), infertility, urinary tract, kidney or bladder disorder or prostate disorder?	☐	☐
	E4	Endocrine System including but not limited to: diabetes, thyroid disorder, adrenal disorder, enlargement of the lymph nodes, connective tissue disorder?	☐	☐
	E5	Ear or Eye System including but not limited to: eye disorder, ear disorder?	☐	☐
	E6	Respiratory System including but not limited to: allergies, asthma, emphysema, sinus or nasal disorder, lung disease or disorder, shortness of breath?	☐	☐
	E7	Nervous System including but not limited to: epilepsy or other seizures, headaches, multiple sclerosis, Parkinson's disease?	☐	☐
	E8	Muscular or Skeletal System including but not limited to: arthritis, fibromyalgia, back disorder, joint disorder, musculoskeletal disorder, skin disorder, chronic fatigue syndrome.	☐	☐
	E9	Cancer including but not limited to: cancer, tumor, abnormal growth, carcinoma in situ?	☐	☐
	E10	Behavioral Health including but not limited to: attention deficit disorder, psychological disorder, suicide attempt, eating disorder?	☐	☐
	E11	Other Conditions including but not limited to: organ or other type of transplant or implant, breast disorder, lupus?	☐	☐
F		Within the last five years, has anyone named in this application to be covered by this insurance had any other injury, illness or treatment for any conditions not already listed: been hospitalized or been scheduled for hospitalization; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommend to have a test or surgery which was not performed for any reason not already mentioned in this application? We are not seeking the results of HIV antibody test.	☐	☐
G		If anyone named in this application is taking medication or has had prescribed or recommended any medication during the period of time related to your answer (i.e. past five years, past 10 years or currently taking), please list all those medication, dosages and what medical condition is being treated or were treated by each medication in the space provided below. (Attach additional pages as needed and sign the additional pages)	☐	☐

If Yes to any questions above, provide details below:

Question #	Name: (yours, spouse's or dependent's)	Condition: Give full details for each question answered "yes," state the condition duration and degree of recovery	Date(s) of Diagnosis & Treatment:	Medication:	Dosage:	Refills per year:	Still Prescribed?	
							YES	NO
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐
							☐	☐

If more space is needed, please attach a separate sheet.

Employee Signature: _____ Date: _____