ESC100 Employee Health Questionnaire

	First Name / Last Name	DOB		First Name	DOB
Employee			Child		
Spouse			Child		
Child			Child		

Please provide answers to the following questions:

☐ Yes ☐ No 1 In the past two (2) years, has any person to be insured received medical care for or had treatment for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, organ transplant, paralysis, loss of 2 or more limbs, blindness, AIDS, AIDS related complex, or immune deficiency, mental illness requiring medication, treatment for alcoholism or drug abuse or has been hospitalized or advised to have any diagnostic tests or surgery for any condition? ***If yes, please list condition & name of patient/s below***:

_____

_____

☐ Yes ☐ No 2. Is anyone listed above currently taking any prescriptions. ***if yes, list name of patient, drug below***:

_____

_____

_____

Authorization to receive, use and disclose protected health information to ESC100. NOTE: HEALTH INFORMATION REQUIRED FOR UNDERWRITING PURPOSES ON BEHALF OF THE ESC100 DISTRICT SELF-FUNDED HEALTH & WELFATE PLAN.

I specifically authorize the use and disclosure of my Protected Health Information. In addition, I specifically authorize the release of data and information relating to substance abuse (alcohol/drug), mental health (includes psychological testing) and/or HIV-related information (AIDS-related testing.) I have had an opportunity to review and understand the content of this authorization form. I understand my rights to receive a copy of this form upon written request. I understand this authorization is voluntary and my right to refuse to complete this authorization which will NOT affect my eligibility to receive benefits. By signing this authorization, I am confirming that it accurately reflects my wishes. A photocopy of this form should be as valid as original. This authorization **This authorization ends SEPTEMBER 1, 2022** or until I exercise my right to cancel this authorization in writing.

Print Name: _____ Phone Number: _____

Signature: _____ Date: _____