

**III (a). ACTIVELY AT WORK EMPLOYEE INITIAL OPEN-ENROLLMENT INSURABILITY PROFILE:**

For Actively At Work Employees applying during Initial Open-Enrollment.

All others use Standard Insurability Profile

Please check YES or NO to each question.

1. **5 YEARS:** In the past 5 years have you received Medical Advice, Consultation, or Treatment for any of the following:  YES  
 NO

- Alzheimer's Disease, Memory Loss, Dementia, Psychosis, Schizophrenia, Mental Retardation
- Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis, Parkinson's Disease/Parkinsonism
- Post-Polio Syndrome, Demyelinating Disease, Other Neurological Conditions affecting the brain or spinal cord
- Mixed Connective Tissue Disease, Scleroderma, Muscular Dystrophy, Other Muscular Conditions Causing Limits
- Kidney Disease, Liver Cirrhosis, Hepatitis, Amputation-Due to Disease
- Metastatic Cancer, Brain or Spinal Tumors-benign or malignant, Multiple Myeloma
- 2 or more Strokes or Transient Ischemic Attacks, Double Heart Valve Replacement , Organ or Bone Marrow Transplants
- Diabetes and Peripheral Vascular Disease, Skin Ulcers OR Stroke/TIA
- Peripheral Vascular Disease and Smoking
- AIDS - *You need not answer "yes" if you have only tested positive for Human Immunodeficiency Virus (HIV) In addition, you need not answer "yes" if you do not have, or have never been tested for HIV or AIDS. You are obligated to answer "yes" if you have actually been diagnosed as having AIDS.*

2. **1 YEAR:** In the *past year* have you needed assistance or supervision in performing activities of daily living\*, used any Medical Equipment\*\*, or received nursing home care , home health care, or adult day care services?  YES  
 NO

*\*Includes Walking, Dressing, Eating, Taking Medications, Getting In and Out of Bed, Bathing, Toileting, Bowel/ Bladder Control*

*\*\*Wheelchair, Walker, Motorized Scooter, Quad Cane, Dialysis, Catheters, Ventilators, Oxygen, Stairlift, or Home Intravenous Meds*



**STOP!**

If questions 1 OR 2 are checked "Yes", we cannot offer coverage at this time. Do not submit the application.

3. **2 YEARS:** In the *past 2 years* have you received Medical Advice, Consultation, or Treatment for any of the following:  YES  
 NO

▪ Arthritis with Multiple Joint Replacements or Causing Limitations	▪ Compression Fractures
▪ Cancer	▪ Diabetes
▪ Cardiomyopathy or Congestive Heart Failure	▪ Joint Deformities
▪ Chronic Blood Disorders	▪ Lung Disorders such as COPD or Emphysema
▪ Chronic Muscular or Neurological Conditions	▪ Manic-Depression
▪ Vascular Disease or other Circulatory Disease	▪ Multiple Falls or Fractures
▪ Drug/Substance Abuse	▪ Stroke/TIA/Amaurosis Fugax- <b>Single Episode</b>

4. **1 YEAR:** In the *past year* have you been hospitalized overnight, been advised to have surgery, received rehabilitative services including physical or occupational therapy, OR have you received disability income or worker's compensation?  YES  
 NO



- a) Employees applying during Initial Open-Enrollment answering "NO" to questions 3 and 4: Go to SECTION VI
- b) Employees applying during Initial Open-Enrollment Answering "YES" to questions 3 and/or 4: A Phone History Interview and Medical Records are required. Please complete SECTION V: Authorization to Obtain Protected Health Information for Purpose of Determining Insurability