THE INSURANCE EXCHANGE
"Giving Today's Agents More Time to Sell!"

PRESCREEN REQUEST FORM

All information requested in this form is required; please answer to the best of your knowledge.

Group Name: ______________________________

Name	Relationship	Sex	DOB	Height	Weight
	Self	**M** or **F**	/ /	' "	lbs
SSN: - -					
	Spouse	**M** or **F**	/ /	' "	lbs
	Dependent	**M** or **F**	/ /	' "	lbs
	Dependent	**M** or **F**	/ /	' "	lbs
	Dependent	**M** or **F**	/ /	' "	lbs

Medical History

Please answer the following questions for yourself and each person listed above. Please answer completely and truthfully. **Please note that, if you leave out or misrepresent information, we may change your premium.**

☐ **Y** ☐ **N** **1.** Is anyone on this application currently pregnant? If "yes" please provide detailed information including anticipated delivery date, any pregnancy complications, anticipation of multiple births, and/or Cesarean Section.

☐ **Y** ☐ **N** **2.** Has anyone on this application visited any health care professional during the last 10 years for any illness, injury, or health condition? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ **Y** ☐ **N** **3.** Has anyone on this application been hospitalized (inpatient or outpatient) or had surgery in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ **Y** ☐ **N** **4.** Has anyone on this application been prescribed or taken any prescription medications in the past 12 months? If your answer is "yes" please provide detailed information on next page for each person involved.

☐ **Y** ☐ **N** **5.** Does anyone on this application have a health condition, illness, or injury that may require treatment or surgery, or has any health care professional recommended treatment or surgery for any of you that has not been performed? If your answer to either question is "yes" please provide detailed information below for each person involved.

(If more room is needed, please attach a separate sheet and be sure to sign and date it.)

Person Treated	Condition	Dates Treated	Medication	Treatment

______________________________ ______________________________
Employee Signature **Date**

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