FIRSTCAROLINACARE INSURANCE COMPANY
EMPLOYEE HEALTH QUESTIONNAIRE (GROUPS 14 OR LESS EMPLOYEES ONLY)

The confidential information provided on this form will be used to determine premium rates for the applicable employer group. You cannot be declined for coverage based on the information provided on this form and you will not be individually charged a higher premium based on your responses.

No information on this form will be disclosed to your employer.

Employer Name: ____

1. Please provide the following information for all persons to be enrolled in health coverage:

	Name	Sex	Date of Birth	Height	Weight	Use tobacco products?
Employee						□ Yes □ No
Spouse						□ Yes □ No
Child						□ Yes □ No
Child						□ Yes □ No
Child						□ Yes □ No
Child						□ Yes □ No

2. Has anyone listed above been diagnosed with or currently being treated for any of the following conditions? Please check Yes or No and list the name, any treatments received and approximate dates.

Condition		Name/Treatment/Dates	Condition		Name/Treatment/Dates
Back or spinal disorders	□ Yes □ No		Multiple sclerosis	□ Yes □ No	
Paralysis	□ Yes □ No		Stomach/ bowel disorder	□ Yes □ No	
Stroke	□ Yes □ No		Crohn's disease	□ Yes □ No	
Cerebral palsy	□ Yes □ No		High blood pressure	□ Yes □ No	
Parkinson's disease	□ Yes □ No		Diabetes mellitus	□ Yes □ No	
Other neurological disorders	□ Yes □ No		Heart attack	□ Yes □ No	
Liver disorders	□ Yes □ No		Congestive heart failure	□ Yes □ No	
High cholesterol	□ Yes □ No		Other heart condition	□ Yes □ No	
Asthma	□ Yes □ No		Organ transplant	□ Yes □ No	
Other lung disorder	□ Yes □ No		AIDS/HIV*	□ Yes □ No	
Cancer	□ Yes □ No		Eating disorder	□ Yes □ No	
Tumors/ growths	□ Yes □ No		Mental/emotional disorder	□ Yes □ No	
Hemophilia	□ Yes □ No		Rheumatoid arthritis	□ Yes □ No	

* "AIDS" means Acquired Immune Deficiency Syndrome. "HIV" means Human Immunodeficiency Virus.

3. If anyone enrolling as listed above takes prescription medications (including fertility drugs), please explain below:

Name	Drug and dosage	For what condition prescribed

4. Are you or any dependents listed on this form now pregnant? □ Yes □ No If yes, due date:_______________
   Is the pregnancy high risk or expected to have complications? □ Yes □ No If yes, please explain: __________
   ____

5. Has any surgery, hospitalization, diagnostic testing or other medical treatment been received in the last 2 years or recommended for any person on this form? □ Yes □ No If yes, please explain: ___________________________
   ____
   ____
   ____

6. Have you or any dependent listed on this form been turned down for health coverage by any insurer or health plan?
   □ Yes □ No If yes, please explain:____
   ____
   ____
   ____

7. Is any person listed on this form under 65 and covered by Medicare? □ Yes □ No
   If yes, please explain:____
   ____

ACKNOWLEDGEMENT

The information provided on this form is protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA). FirstCarolinaCare Insurance Company (FCC) will safeguard my PHI and will not disclose it unless I request it or where the disclosure is permitted or required by state or federal law. The PHI provided on this form will be used to determine premium rates for the applicable employer group. I understand that I cannot be declined for coverage based on the information I provide on this form. I understand that by signing this form I attest that all the answers are accurate and complete. I further understand that coverage will be issued in reliance upon the information herein. Any untrue or incomplete information, whether intentional or not, may result in a premium adjustment.

____ ____________________
Employee Signature Date

____ ____________________
Employee's Spouse (if spouse coverage is requested) Date