Q3 Business Technology Corp.
PO Box 15952, Fort Wayne, IN 46885
Phone 260-492-9979 Fax 260-492-9989

Member Name _____ **Birthdate** _____ **Height** _____ **Weight** _____

Employee SSN _____ **Relationship to Employee** _____

Directions: Answer all 14 questions completely. Please print.

Questions 1-11. To the best of your knowledge, has this person had medical treatment or symptoms for the following in the past five (5) years:

1. Brain or nervous system (including seizures, Multiple Sclerosis or MS, aneurysm, fainting, Parkinson's)? ❍ **Yes** ❍ **No**

2. Respiratory system (including asthma, COPD, Cystic Fibrosis)? ❍ **Yes** ❍ **No**

3. Cardiovascular system (including heart attack, circulation, stroke, high blood pressure,valve disorder)? ❍ **Yes** ❍ **No**

4. GI system (including stomach, liver, Hepatitis C, pancreas, Crohns, ulcer, hernia)? ❍ **Yes** ❍ **No**

5. Genito-urinary tract (including kidney, ESRD, prostate, bladder)? ❍ **Yes** ❍ **No**

6. Musculo/skeletal system (including rheutamoid arthritis, arthritis, neck, back, shoulder, hip or knee disorder)? ❍ **Yes** ❍ **No**

7. Reproductive system (including breast, female organs, male organs, complications of pregnancy)? ❍ **Yes** ❍ **No**

8. Cancer, Immune system, Lupus, Acquired Immune Dificiency Syndrome, HIV positive? ❍ **Yes** ❍ **No**

9. Diabetes, sugar in the urine, thyroid, adrenal disorder? ❍ **Yes** ❍ **No**

10. Pregnancy (if currently pregnant include the estimated delivery date in question 13)? ❍ **Yes** ❍ **No**

11. Been hospitalized? ❍ **Yes** ❍ **No**

Question 12. Is this person currently disabled, home or institutional confined? ❍ **Yes** ❍ **No**
If yes and covered by Medicare, please attach a copy of the Medicare ID card.

Question 13. If you answered Yes to any of Questions 1-12, circle condition above and provide details here:

Name(s)	Diagnosis,Prognosis & Treatment	Treatment Dates	Name & Phone # of treating physician(s)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

14. Is this person currently taking any prescription medications? ❍ **Yes** ❍ **No**
If yes, list all prescription medications prescribed for current use here:

Name	Medication	Dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau or other organization, institution or person that has any records or knowledge of me or my health or that of my family listed on this form to give to my employer or its insurers any such information. A photographic copy of this authorization shall be as valid as the original. I hereby certify that the above answers are true and complete to the best of my knowledge.

HIPAA Notice: I authorize the use or disclosure of my individually identifiable health information as described above. This authorization will expire 6 months after date signed below. I may revoke this authorization at any time by notifying the providing organization in writing, but the revocation will not have any effect on any actions that the entity took before it received the revocation.

Member Signature _____ **Date** _____
Employee may sign for minor children