



MEDICAL HISTORY FORM

This form is not intended for any changes in your coverage. Use the "Application For Coverage" instead.

Employee Name, Social Security Number, Employer or Account Name, Account Number, Myself—Height, Weight, Age, My Spouse—Height, Weight, Age, Children

HEALTH INFORMATION: Include information on yourself and on any of your dependents listed for coverage in your group plan. Mark YES or NO for each question. Any question 1 through 7 answered YES must be explained below, where indicated.

- 1. YES NO Have you or any insured dependents (spouse and/or children) ever had, or been advised that you or they have or may have had: back or spinal disorder, heart condition, stroke, or other circulatory disorder, ulcers, cancer or tumors (benign or malignant), intestinal disorders, respiratory disorders, thyroid disorders, kidney or liver disorders, high blood pressure, diabetes, lymph node disorder, substance abuse or drug dependency or abuse, mental/nervous/emotional/personality disorder condition, excessive use of alcohol or alcoholism, Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC) or HIV infection, history of sexually transmitted disease, any immune system disorder, genito-urinary disorders
2. YES NO Have you or your spouse (if listed) either gained or lost over 20 lbs. In the past year?
3. YES NO Are you or any of your dependents now pregnant? If YES, include the due date in the section below.
4. YES NO Have you or any of your dependents been treated or counseled by, consulted with, or prescribed medication (including refills) by a physician or any other physical or mental health care practitioner in the past 12 months?
5. YES NO Have you or any of your dependents been disabled, hospitalized or had a surgical operation in the past five years?
6. YES NO Have you or any of your dependents been counseled or advised that you or they have or may have any disease, disorder, impairment, deformity, injury, chronic or untreatable condition whether active or in remission, or do you or they now have any prosthetic device or implant?
7. YES NO During the past 12 months, have you or your dependents been advised by a physician or other practitioner to have any special examinations or tests such as x-rays, electrocardiograms, heart studies, blood studies, or urine tests? If YES, give details, including reasons and dates.
8. YES NO Have you/your spouse smoked, snuffed or chewed tobacco at any time during the past 24 months?

PLEASE NOTE: Failure to provide full details in the area below may result in a delay in processing. If additional space is needed, continue writing on the reverse side of this form.

Table with 6 columns: Ques. No., Name of Person Treated, Nature of Condition and Diagnosis, Duration Dates (From Mo./Yr., To Mo./Yr.), Explain Treatment Including Dates of Disability Hospitalization, Medication, Surgery, Test Results, Degree of Recovery

I certify that all information above is true and complete to the best of my knowledge and belief, and understand that my coverage may be void if this is not correct. I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release

information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to BCBSD or its designee for purposes reasonably related to this contract.

Employee's Signature, Date—month, day, year

PLEASE RETURN THIS FORM TO YOUR COMPANY'S BENEFIT ADMINISTRATOR PROMPTLY.

Your Administrator will forward it to: Blue Cross Blue Shield of DE Local Marketing (1-2-28) P.O. Box 1991 Wilmington, DE 19899-1991