

# GCPA Insurance Questionnaire

Name \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_

SS# \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

## Health Questions

1. Are you currently hospitalized, bedridden, confined to a nursing facility; have you received Home Health Care within the past 90 days; do you require the use of a wheelchair/cane or has such care been medically advised?    Y    N
2. Within the past two years have you been hospitalized two or more times?    Y    N
3. Do you now have or, within the past two years have you had, or been advised by a physician to have treatment, or surgery for:
  - a. Heart, Coronary or Carotid Artery Disease (not including high blood pressure); Peripheral Vascular Disease; Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart; Stroke; Transient Ischemic Attacks (TIA); or Heart Rhythm Disorders?    Y    N
  - b. Alzheimer's, Senile Dementia, Organic Brain, Parkinson's Disease, Lou Gehrig's Disease (ALS), Multiple Sclerosis, Paralysis, Epilepsy or Seizure Disorder?    Y    N
  - c. Mental or Nervous Disorder requiring Psychiatric Care; Alcohol or Drug (prescription or non-prescription) Abuse; Cirrhosis of the Liver; Hepatitis; or any disease disorder of the Pancreas?    Y    N
  - d. Insulin Dependent Diabetes, Addison's Disease, Lupas or any Connective Tissue Disorder?    Y    N
  - e. Disabling Arthritis; Paget's Disease, Osteoporosis causing compression fractures, or any other Degenerative Bone Disease?    Y    N
  - f. Kidney or Renal Insufficiency or Failure, Kidney or Renal Dialysis, Chronic Cystitis, Blood Disorder or Severe Anemia?    Y    N
  - g. Cancer (except skin cancer), Melanoma, Hodgkin's Disease or Leukemia?    Y    N
  - h. Emphysema, Chronic Obstructive Pulmonary or Lung Disease, or other Chronic Pulmonary Disorder requiring the use of Oxygen?    Y    N
4. Have you been advised to have surgery or medical tests that have not been performed or have you had medical test(s) for which you have not received the results?    Y    N

5. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS caused by the HIV infection or other sickness or condition derived from such infection?    Y    N

6. Have you used tobacco within the last 12 months?    Y    N

## Medications

Current Medication and Dosage

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_____	_____	_____
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## Notes

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### \*Medicare Supplement Only

Do you currently have Medicare Supplement Insurance?    Y    N

If so, is this a replacement?    Y    N

Medicare # \_\_\_\_\_