HEALTH APPLICATION COVER PAGE

Please take a moment to review the following tips before completing and returning your health insurance application and questionnaire:

1. Print clearly and complete the application in blue or black ink.
2. If you make any **changes** while completing this form (for example, you cross out something you wrote), be sure to **initial and date** those changes.
3. If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form the will be attached to your application. **Please Note: This may delay your effective date of coverage.**
4. List the height and weight for each applicant.
5. List the date of birth for each applicant.
6. If you answered "yes" to any of the health history questions, please provide complete details in the section provided.

NOTICE OF MEMBER PROTECTION POLICY: You must provide truthful and complete answers to the following questions to the best of your ability. Failure to do so may impact your insurance coverage and will be a detriment to other farmers and agribusinesses that are members of the Farmers' Health Cooperative. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. Our insurer has the right to review all of your medical records to verify accuracy of your information during the first 24 months you are covered. However, do not assume all of your medical records will be reviewed before approving your application.

Having sound policies and practices is critical to any insurance program, but especially to a member-owned and governed cooperative. If we issue coverage and later discover that you misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Loss of coverage may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage, you must fully disclose and answer all health history questions. These policies are in place to protect all cooperative members.

ASA Agri-Services Agency

Farmers' Health Cooperative of Wisconsin

APPLICATION FOR INSURANCE – HEALTH QUESTIONNAIRE

Please list below all persons applying for coverage:							
Name (First, middle initial, last)	**Date of Birth**	**Height**	**Weight**	**Name** (First, middle initial, last)	**Date of Birth**	**Height**	**Weight**

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions.

1. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following? (please check all conditions that apply):

CIRCULATORY SYSTEM
a) heart disease or disorder [ ] Yes [ ] No
b) stroke [ ] Yes [ ] No
c) circulatory disorder [ ] Yes [ ] No
d) chest pain [ ] Yes [ ] No
e) high or low blood pressure [ ] Yes [ ] No
f) elevated cholesterol and/or triglyceride levels [ ] Yes [ ] No
g) anemia or blood disorder [ ] Yes [ ] No

DIGESTIVE SYSTEM
a) ulcers [ ] Yes [ ] No
b) stomach disorder [ ] Yes [ ] No
c) liver/pancreas disorder [ ] Yes [ ] No
e) intestinal disorder (ie. colitis, Crohn's disease) [ ] Yes [ ] No
f) hernia [ ] Yes [ ] No
g) rectal disorder [ ] Yes [ ] No

GENITOURINARY SYSTEM
a) menstrual disorder [ ] Yes [ ] No
b) genital disorder [ ] Yes [ ] No
c) sexual dysfunction [ ] Yes [ ] No
d) pregnancy complications (ie. premature birth, miscarriage, c-section) [ ] Yes [ ] No
e) infertility [ ] Yes [ ] No
f) urinary/tract/kidney/bladder disorder [ ] Yes [ ] No
g) prostate disorder [ ] Yes [ ] No
h) abnormal Pap smear results [ ] Yes [ ] No
i) sexually transmitted disease or disorder [ ] Yes [ ] No

NERVOUS SYSTEM
a) epilepsy or other seizures [ ] Yes [ ] No
b) headaches [ ] Yes [ ] No
c) multiple sclerosis [ ] Yes [ ] No
d) disease or disorder of the brain [ ] Yes [ ] No

EYE OR EAR
a) eye disorder [ ] Yes [ ] No
b) ear disorder [ ] Yes [ ] No

BEHAVIORAL HEALTH
a) attention deficit disorder [ ] Yes [ ] No
b) psychological disorder [ ] Yes [ ] No
c) suicide attempt [ ] Yes [ ] No
d) eating disorder [ ] Yes [ ] No
e) depression [ ] Yes [ ] No
f) anxiety [ ] Yes [ ] No
g) nervous, mental or emotional disorder [ ] Yes [ ] No
h) nervous system disease or disorder [ ] Yes [ ] No

ENDOCRINE SYSTEM
a) diabetes [ ] Yes [ ] No
b) thyroid disorder [ ] Yes [ ] No
c) adrenal disorder [ ] Yes [ ] No
d) enlargement of the lymph-nodes [ ] Yes [ ] No
e) connective tissue disorder [ ] Yes [ ] No
f) elevated blood sugar [ ] Yes [ ] No
g) sugar albumin or blood in urine [ ] Yes [ ] No

RESPIRATORY SYSTEM
a) allergy(ies) [ ] Yes [ ] No
b) asthmas [ ] Yes [ ] No
c) emphysema [ ] Yes [ ] No
d) sinus or nasal disorder [ ] Yes [ ] No
e) lung disease or disorder [ ] Yes [ ] No
f) shortness of breath [ ] Yes [ ] No
g) hayfever [ ] Yes [ ] No
h) pneumonia [ ] Yes [ ] No

MUSCULAR or SKELETAL
a)arthritis [ ] Yes [ ] No
b) fibromyalgia [ ] Yes [ ] No
c) back disorder [ ] Yes [ ] No
d) joint disorder [ ] Yes [ ] No
e) musculoskeletal disorder [ ] Yes [ ] No
f) skin disorder [ ] Yes [ ] No
g) chronic fatigue syndrome [ ] Yes [ ] No
h) acne [ ] Yes [ ] No
i) throat disease or disorder [ ] Yes [ ] No
j) paralysis [ ] Yes [ ] No
k) spinal cord disorder [ ] Yes [ ] No

CANCER
a) cancer [ ] Yes [ ] No
b) tumor [ ] Yes [ ] No
c) abnormal growth [ ] Yes [ ] No
d) carcinoma in situ [ ] Yes [ ] No
e) cyst [ ] Yes [ ] No
f) polyp [ ] Yes [ ] No

OTHER
a) organ or other type of transplant/implant [ ] Yes [ ] No
b) breast disorder [ ] Yes [ ] No
c) lupus [ ] Yes [ ] No
d) abnormal mammogram results [ ] Yes [ ] No
e) sleep disorder [ ] Yes [ ] No
f) sleep apnea [ ] Yes [ ] No
g) hepatitis [ ] Yes [ ] No

2. Have you, or has any person to be insured:

a) smoked or used any tobacco product in the past twelve months? [ ] Yes [ ] No

b) used drugs other than prescribed by a physician? [ ] Yes [ ] No

c) been advised to have treatment or counseling for alcohol or drug abuse? [ ] Yes [ ] No

3. Are you, or is any person to be insured, now pregnant? [ ] No [ ] Yes Expected delivery date ____/____/____
[ ] Single birth [ ] Multiple birth, number ____

4. Within the past ten years, has anyone named in this application had any other injury, illness or treatment for any condition not already listed; been hospitalized or scheduled for hospitalization; had any chronic condition for which you are not seeking active care but seek care on a routine monitoring basis; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? (*We are not seeking the results of HIV Antibody test)* [ ] Yes [ ] No

5a. In the space below, please list and provide complete details if you answered "Yes" to any of the above questions. (Attach additional pages as necessary and sign the additional pages.) (Be sure to note the most recent readings for anyone with High/Low Blood Pressure, Elevated Cholesterol or Triglyceride levels or Glaucoma. Be sure to indicate frequency of visits and date of last visit for anyone receiving Behavioral Health counseling.)

Question #	Person Treated	Date(s) Treated		Illness or Health Condition (include diagnosis/prognosis)	Treatment Status (Ongoing, routine monitoring, resolved, etc.)
		Beginning	Ending		

5b. In the space below, please list all persons who are currently taking or have taken medication(s) within the past 10 years. (Attach additional pages as necessary and sign the additional pages.)

Person Taking Medication	Name of Medication	Dosage (mg) and Frequency (i.e. one pill per day)	Diagnosis (Reason for taking medication)	Date Prescribed	Date Discontinued

I hereby apply for coverage as indicated with Agri-Services Agency (ASA), with insurance coverage provided by Anthem. I understand that representations made herein will be used by ASA to determine final rates for my coverage. By signing below, I hereby authorize any physician, hospital, or other medical facility or professional to furnish to ASA, or its representatives, any medical record or information pertaining to me or any dependent family member in this application, even if it would otherwise be deemed confidential, on presentation of this authorization bearing my signature or a photocopy thereof.

Name of Applicant (*please print*): ________________________________ Date: ____/____/____

Signature of Applicant: ____ Contact phone number (_____) ______________

For questions please contact: ASA Sales/Service Center Phone: 1-800-654-8840 or Fax: 1-570-888-9197