



## 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 that 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.

**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 Aetna. 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**