

Last Name of Employee:	First Name of Employee:
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If you answered YES to the Medical History Disclosure question on the first page, please provide details below. Do not provide genetic information.

Section 1: Full Medical History Disclosure
Please answer questions for yourself and anyone in your family applying for coverage

	Patient's First Name	Description of Diagnosis/Treatment/Symptoms	Date Began	Date Ended or Ongoing	Physician Name and Phone Number
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					

Section 2: Medication Disclosure
Prescription medications, including over the counter or "OTC" medicine prescribed or recommended by a physician or practitioner for yourself and anyone in your family applying for coverage - attach additional sheets if needed

	Patient's First Name	Description of Condition(s) Being Treated	Medication Name	Dosage	Frequency	Date Prescribed	Date Ended or Ongoing	Physician Name and Phone Number
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								