

Section VII. Medical Questions

**IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE
(BASED ON YOUR ANSWERS IN SECTION(S) V & VI), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.**

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage. If you answered NO to all questions in this Section, please continue to Part B.

	YES	NO
1. Are you currently confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently receive home health care services or, in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you currently have a terminal illness or are you currently in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you currently receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for the following conditions:		
a. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>
b. angina, atherosclerosis, arteriosclerosis, peripheral vascular disease, heart attack, irregular heartbeat, atrial fibrillation, cardiomyopathy, congestive heart failure, angioplasty, stent placement, carotid artery disease, coronary artery disease (CAD), heart valve surgery, coronary bypass, cardiac pacemaker, implantable or subcutaneous defibrillator? (You should answer NO if your only treatment is with maintenance medication.)	<input type="checkbox"/>	<input type="checkbox"/>
c. Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease)?	<input type="checkbox"/>	<input type="checkbox"/>
d. Paget's disease, rheumatoid arthritis, disabling arthritis, systemic lupus, osteoporosis with fractures, or paralysis? ...	<input type="checkbox"/>	<input type="checkbox"/>
e. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
f. diabetes with hypertension requiring three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	<input type="checkbox"/>	<input type="checkbox"/>
g. diabetes with: neuropathy, retinopathy, vascular disease, or tobacco use?	<input type="checkbox"/>	<input type="checkbox"/>
h. chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or any other chronic lung or respiratory disorder requiring the use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
i. major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	<input type="checkbox"/>	<input type="checkbox"/>
j. dementia, senility, Alzheimer's disease, or organic brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>
k. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder? ...	<input type="checkbox"/>	<input type="checkbox"/>
l. hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease?	<input type="checkbox"/>	<input type="checkbox"/>
m. stroke or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant other than corneas?	<input type="checkbox"/>	<input type="checkbox"/>
7. In the past five (5) years, have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/>	<input type="checkbox"/>