SHORTINO & ASSOCIATES
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Group Census

Company Name:_____ Type of Industry:_____

Company Address:_____

_____

Phone:_____ Fax:_____

Effective Date:_____

Company contact name and e-mail/fax #: _____

_____

Employee Name	Date of Birth	Sex	Dependent Status*	Smoker/ Non-Smoker	Home Zip Code	Employment Date

* E = Employee Only
E/S = Employee & Spouse
E/C = Employee & Children (# of children)
E/S/C = Employee, Spouse & Number of Children

SMALL GROUP EMPLOYER MEDICAL QUESTIONNAIRE

Complete the following questions **to the best of your knowledge** for eligible employees, their dependents, and any COBRA participants, state continuation participants, or state dependent continuation participants.

1. How many employees or dependents have had a claim of $5000 or more in the past 12 months?_____

2. How many employees or dependents have been advised to have surgery or medical treatment in the past 6 months that has not yet been performed, or been hospitalized or had surgery in the past 3 years?_____

3. How many employees or dependents have been advised, diagnosed, or treated by a physician in the past 5 years for:
(Enter the number of employees or dependents with the condition and provide details on the next page.)

A.	_____Stroke	_____Heart Disease or Disorder
	_____Circulatory Disease or Disorder	_____Vascular Disease or Disorder
	_____High Blood Pressure	
B.	_____Cancer	_____Tumors
	_____Leukemia	_____Lupus
	_____Chronic Skin Condition	_____Any other Systemic Disease
C.	_____Multiple Sclerosis	_____Paralysis
	_____Osteoarthritis	_____Other Severe Arthritis
	_____Joint Disorders	_____Back Disorders
	_____Muscle Disorders	_____Bone Disorders
D.	_____Asthma	_____Emphysema
	_____Respiratory and Lung Disorders	
E.	_____Diabetes	_____Pancreas
	_____Growth Disorder	_____Endocrine Disorder
F.	_____AIDS	_____Tested Positive for HIV
	_____Immune System Disorders	_____Blood Disorders
G.	_____Hepatitis	_____Liver Disorder
	_____Digestive System Disease or Disorder	_____Colon Disorder
	_____Kidney Disorder	_____Prostate Disorder
	_____Reproductive Organs Disorder	_____Infertility
	_____Urinary Tract Disorder	
H.	_____Nervous System/Brain/Seizure Disorders	_____Mental/Emotional Disorders
	_____Alcohol/Drug/Substance Abuse or Dependency	
I.	_____Organ Transplant	_____Bone Marrow Transplant
J.	_____Other	

4. How many employees or dependents are currently pregnant?_____

If you have indicated medical conditions on the previous page, please provide details for each person with the condition. If more than one person has the condition, add a separate entry for each person. See the example in the first line.

Name of Person with Condition (Optional)	Age	Gender	Relation to Insured*	Condition/ Diagnosis Details	Treatment/ Medication Details	Date(s) Treated	Current Status
John Doe *"Example"*	12	M	Child	Appendicitis	Surgery to remove appendix	01/01/99 to 01/05/99	Full recovery

* Employee, Spouse, Child