

# Whitley Benefits

COMPANY NAME

ADDRESS

CITY, STATE, ZIP

TELEPHONE

FAX

CONTACT PERSON

CONTACT EMAIL

NATURE OF BUSINESS

NUMBER OF YEARS IN BUSINESS

NUMBER OF EMPLOYEES	EMPLOYER CONTRIBUTION/WAIT	RENEWAL DATE	CARRIER	
TOTAL	EMPLOYEE	CURRENT	CURRENT	# YRS
ELIGIBLE	DEPENDENTS	DESIRED	PREVIOUS	# YRS
PARTICIPATING	WAITING PERIOD		PREVIOUS	# YRS
COBRA	CARVE OUT?		PREVIOUS	# YRS

HMO CURRENT	HMO RENEWAL	PPO CURRENT	PPO RENEWAL	VISION CURRENT	VISION RENEWAL	DENTAL CURRENT	DENTAL RENEWAL
EE							
EE+SP							
EE+CH							
FAMILY							

HMO	PPO	POS	HSA	COINSURANCE	PCP/SP COPAY	OUT OF POCKET MAX	LIFETIME MAX
DEDUCTIBLE							

HMO	PPO	POS	HSA	DEDUCTIBLE	COINSURANCE	OUT OF POCKET MAX	LIFETIME MAX
DEDUCTIBLE				DENTAL: PPO DMO VOLUNTARY	VISION	ST DISABILITY LT DISABILITY	LIFE

CIRCLE ALL THAT APPLY TO EMPLOYEES, SPOUSES, AND/OR DEPENDENTS. FOR ANY CONDITION CIRCLED EMPLOYEE MUST FILL OUT HEALTH HISTORY FORM.

ARTHRITIS BACK/NECK CANCER CARDIAC TESTS CROHNS DIABETES EPILEPSY HEART DISORDER HIV/AIDS HYPERTENSION KIDNEY DISORDER LUNG DISORDER

LUPUS MD MS OPEN HEART SURGERY ORGAN TRANSPLANT PREGNANCY PSYCHOLOGICAL DISORDER STROKE ALCOHOL/DRUG ABUSE

ANY OTHER CONDITION NOT LISTED:



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	GENDER		DATE OF BIRTH	AGE	HEIGHT	WEIGHT
EMPLOYEE (EE)	M	F				
SPOUSE (SP)	M	F				
DEPENDENT 1 (DEP 1)	M	F				
DEPENDENT 2 (DEP 2)	M	F				
DEPENDENT 3 (DEP 3)	M	F				
DEPENDENT 4 (DEP 4)	M	F				
DEPENDENT 5 (DEP 5)	M	F				

1	Is anyone currently ill or pregnant?	YES	NO	EE	SP	DEP # ___
2	Is diagnostic testing, surgery or any future treatment being recommended or contemplated?	YES	NO	EE	SP	DEP # ___

**WITHIN THE PAST 5 YEARS HAVE ANY INDIVIDUALS BEEN DIAGNOSED WITH OR TREATED FOR:**

4	Chest pain, blood pressure, heart attack, or other diseases of the heart, blood vessels, or circulatory system, or been diagnosed/treated for stroke, TIA (mini-stroke) or paralysis?	YES	NO	EE	SP	DEP # ___
5	Psychological or mental disorder, emotional or nervous disorder, depression or hypertension?	YES	NO	EE	SP	DEP # ___
6	Cancer, tumor or other malignancy?	YES	NO	EE	SP	DEP # ___
7	Kidney or other organ disorder or have had or have been recommended to have an organ transplant?	YES	NO	EE	SP	DEP # ___
8	Emphysema, other respiratory or lung diseases or breathing conditions?	YES	NO	EE	SP	DEP # ___
9	AIDS or HIV or other immune system disorders?	YES	NO	EE	SP	DEP # ___
10	Diabetes? If Yes, give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.	YES	NO	EE	SP	DEP # ___
11	Arthritis? If yes, specify type, extent of disability and treatment received.	YES	NO	EE	SP	DEP # ___
12	Been confined in a hospital, clinic, sanitarium or other medical facility?	YES	NO	EE	SP	DEP # ___
13	Back or neck problems including spinal manipulation?	YES	NO	EE	SP	DEP # ___
14	Crohns Disease, Lupus, Muscular Dystrophy, Multiple Sclerosis, or Epilepsy?	YES	NO	EE	SP	DEP # ___
15	Drug or alcohol abuse?	YES	NO	EE	SP	DEP # ___

QSTN #	ILLNESS OR DIAGNOSIS	DATE OF DIAGNOSIS	TREATMENT TYPE AND DATE	PROGNOSIS

MEDICATION	DOSAGE	TAKEN FOR	EMPLOYEE SPOUSE OR DEPENDENT
			EE SP DEP # ___
			EE SP DEP # ___
			EE SP DEP # ___
			EE SP DEP # ___
			EE SP DEP # ___
			EE SP DEP # ___