

BLACK, GOULD & ASSOCIATES, INC.

Census

	Gender (M) or (F)	DOB	Coverage Requested					Spouse Age	# of CH	Home Zip Code	Home State	***Occupation	***Monthly Salary	On COBRA
			EE only	EE + SP	EE + CH	EE + FM	WV*							
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2														
3														
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28														

*WV = Eligible employees who are waiving coverage
 **NC = Not eligible for coverage (i.e. part time or waiting for enrollment)
 *** = Salary and Occupation are only needed for Disability Quote.

Employee and Family Medical Questionnaire (Groups 2-25)

Section 1: Employer/Employee Information

Employer Name: _____

Names of Family Members Applying for Coverage	Relationship	Date of Birth	Gender Male/Female	Height	Weight
	Employee				
	Spouse				
	Dependent				
	Dependent				
	Dependent				

Section 2: Family Health History

Within the past five (5) years has a physician or other licensed healthcare practitioner ("practitioner") diagnosed or treated you or anyone in your family applying for coverage, or is anyone currently getting treatment? Use an "X" to mark "YES" or "NO" in the boxes heading each category of conditions below and mark with an "X" any of the following conditions that apply.

For all "YES" answers and conditions that you mark with an "X", provide details in the table on the next page.

A. Heart/Circulatory <input type="checkbox"/> YES <input type="checkbox"/> NO	D. Cancer/Tumors <input type="checkbox"/> YES <input type="checkbox"/> NO	H. Bones/Muscles/Joints <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> A1. Anemia <input type="checkbox"/> A2. Angina <input type="checkbox"/> A3. Angioplasty/Stent <input type="checkbox"/> A4. Aneurysm <input type="checkbox"/> A5. Blood Clots <input type="checkbox"/> A6. Blood Disorder <input type="checkbox"/> A7. Bypass <input type="checkbox"/> A8. Cardiac Arrhythmia <input type="checkbox"/> A9. Chest Pain <input type="checkbox"/> A10. Congestive Heart Failure <input type="checkbox"/> A11. Coronary Heart Disease <input type="checkbox"/> A12. Heart Murmur <input type="checkbox"/> A13. Hemophilia <input type="checkbox"/> A14. High/Low Blood Pressure <input type="checkbox"/> A15. High Cholesterol <input type="checkbox"/> A16. Pacemaker <input type="checkbox"/> A17. Palpitations <input type="checkbox"/> A18. Sick Cell Anemia <input type="checkbox"/> A19. Stroke/TIA <input type="checkbox"/> A20. Varicose Veins <input type="checkbox"/> A21. Ventricular Tachycardia <input type="checkbox"/> A22. Other (_____)	<input type="checkbox"/> D1. Brain <input type="checkbox"/> D2. Breast <input type="checkbox"/> D3. Colon <input type="checkbox"/> D4. Cyst <input type="checkbox"/> D5. Hodgkin's Disease <input type="checkbox"/> D6. Leukemia <input type="checkbox"/> D7. Liver <input type="checkbox"/> D8. Lung <input type="checkbox"/> D9. Lymphoma <input type="checkbox"/> D10. Melanoma <input type="checkbox"/> D11. Ovarian <input type="checkbox"/> D12. Pituitary <input type="checkbox"/> D13. Prostate <input type="checkbox"/> D14. Stomach <input type="checkbox"/> D15. Testicular <input type="checkbox"/> D16. Thyroid <input type="checkbox"/> D17. Other (_____)	<input type="checkbox"/> H1. Bulging/Herniated Disk <input type="checkbox"/> H2. Carpal Tunnel Syndrome <input type="checkbox"/> H3. Fibromyalgia/CFS <input type="checkbox"/> H4. Fractures (Open or Closed) <input type="checkbox"/> H5. Gout <input type="checkbox"/> H6. Joint Replacement (Type: _____) <input type="checkbox"/> H7. Knee <input type="checkbox"/> H8. Muscular Dystrophy <input type="checkbox"/> H9. Neck/Back <input type="checkbox"/> H10. Shoulder <input type="checkbox"/> H11. Spina Bifida <input type="checkbox"/> H12. Sprain/Strain <input type="checkbox"/> H13. Other (_____)
	E. Neurological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> E1. Alzheimer's Disease <input type="checkbox"/> E2. Cerebral Palsy <input type="checkbox"/> E3. Epilepsy <input type="checkbox"/> E4. Head Injury <input type="checkbox"/> E5. Migraines <input type="checkbox"/> E6. Multiple Sclerosis <input type="checkbox"/> E7. Neuritis <input type="checkbox"/> E8. Paralysis/Hemiplegia <input type="checkbox"/> E9. Parkinson's Disease <input type="checkbox"/> E10. Seizures/Convulsions <input type="checkbox"/> E11. Other (_____)	I. Psychological <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> I1. ADD/ADHD <input type="checkbox"/> I2. Alcoholism <input type="checkbox"/> I3. Anxiety <input type="checkbox"/> I4. Autism <input type="checkbox"/> I5. Bipolar <input type="checkbox"/> I6. Depression <input type="checkbox"/> I7. Drug Abuse <input type="checkbox"/> I8. Eating Disorder <input type="checkbox"/> I9. Schizophrenia <input type="checkbox"/> I10. Suicide Attempt <input type="checkbox"/> I11. Other (_____)
B. Eyes/Ears/Nose/Throat <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> B1. Acoustic Neuroma <input type="checkbox"/> B2. Cataracts <input type="checkbox"/> B3. Chronic Sinusitis <input type="checkbox"/> B4. Cleft Lip/Palate <input type="checkbox"/> B5. Detached Retina <input type="checkbox"/> B6. Deviated Septum <input type="checkbox"/> B7. Ear Infections <input type="checkbox"/> B8. Glaucoma <input type="checkbox"/> B9. Retinopathy <input type="checkbox"/> B10. Other (_____)	F. Transplants <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> F1. Pending <input type="checkbox"/> F2. On Waiting List <input type="checkbox"/> F3. Completed Transplant <input type="checkbox"/> F4. Bone Marrow <input type="checkbox"/> F5. Stem Cell <input type="checkbox"/> F6. Organ (Type: _____)	J. Diabetes/Endocrine <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> J1. Diabetes controlled by: <input type="checkbox"/> a. Diet <input type="checkbox"/> b. Oral Medication <input type="checkbox"/> c. Insulin <input type="checkbox"/> d. Other (_____)
C. Immune <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> C1. ALS <input type="checkbox"/> C2. AIDS <input type="checkbox"/> C3. HIV+ <input type="checkbox"/> C4. Immuno Deficiency <input type="checkbox"/> C5. Lupus <input type="checkbox"/> C6. Psoriasis <input type="checkbox"/> C7. Scleroderma <input type="checkbox"/> C8. Other (_____)	G. Arthritis <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> G1. Arthritis <input type="checkbox"/> G2. Osteoarthritis <input type="checkbox"/> G3. Rheumatoid Arthritis <input type="checkbox"/> G4. Other (_____)	K. Reproductive <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> K1. Breast Disorder <input type="checkbox"/> K2. Endometriosis <input type="checkbox"/> K3. Fibroids <input type="checkbox"/> K4. Menstrual Disorder <input type="checkbox"/> K5. Ovarian Cysts <input type="checkbox"/> K6. Other (_____)

L. Lung/Respiratory	<input type="checkbox"/> YES <input type="checkbox"/> NO	M. Intestinal	<input type="checkbox"/> YES <input type="checkbox"/> NO	N. Liver/Kidney/Urinary	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> L1. Allergies		<input type="checkbox"/> M1. Acid Reflux/GERD		<input type="checkbox"/> N1. Bladder Disorder	
<input type="checkbox"/> L2. Asthma		<input type="checkbox"/> M2. Colitis/IBS		<input type="checkbox"/> N2. Cirrhosis	
<input type="checkbox"/> L3. COPD (On Oxygen? _____)		<input type="checkbox"/> M3. Colon Disorder		<input type="checkbox"/> N3. Gaucher's Disease	
<input type="checkbox"/> L4. Cystic Fibrosis		<input type="checkbox"/> M4. Crohn's Disease		<input type="checkbox"/> N4. Hepatitis (Type: _____)	
<input type="checkbox"/> L5. Emphysema		<input type="checkbox"/> M5. Diverticulitis/Diverticulum		<input type="checkbox"/> N5. Jaundice	
<input type="checkbox"/> L6. Lung Disorder		<input type="checkbox"/> M6. Gallbladder		<input type="checkbox"/> N6. Kidney Disorder	
<input type="checkbox"/> L7. Pneumonia		<input type="checkbox"/> M7. Gastric Bypass		<input type="checkbox"/> N7. Kidney Stones	
<input type="checkbox"/> L8. Sarcoidosis		<input type="checkbox"/> M8. Hiatal Hernia/Reflux		<input type="checkbox"/> N8. Liver Disorder	
<input type="checkbox"/> L9. Sleep Apnea		<input type="checkbox"/> M9. Pancreatitis		<input type="checkbox"/> N9. Polycystic Kidney	
<input type="checkbox"/> L10. Tuberculosis		<input type="checkbox"/> M10. Ulcer		<input type="checkbox"/> N10. Prostate	
<input type="checkbox"/> L11. Valley Fever		<input type="checkbox"/> M11. Ulcerative Colitis		<input type="checkbox"/> N11. Renal Failure	
<input type="checkbox"/> L12. Other (_____)		<input type="checkbox"/> M12. Other (_____)		<input type="checkbox"/> N12. Other (_____)	

Please answer the following questions for yourself and for anyone in your family applying for coverage:

- YES NO Is anyone currently pregnant or an expectant parent?
Due date: _____
 Yes No a. Has the pregnancy been confirmed by a physician or practitioner?
 Yes No b. Pregnancy complications?
 Yes No c. Multiple births expected?
- YES NO Is anyone currently, or in the past five years has anyone been, a patient in a hospital, clinic, surgi-center, urgent care facility, or other medical facility as an inpatient or outpatient?
- YES NO Does anyone currently use tobacco products, including cigarettes, pipes, cigars or chewing tobacco?
- YES NO Does anyone currently have, or in the past 12 months has anyone had, any of the following?
 abnormal test or physical results pending test results
 health condition, illness or injury that may require treatment or surgery
 tests, treatment or surgery advised unexplained weight gain/loss or fatigue
 Worker's Compensation injury or illness condition not mentioned above in Section 2

Please use this table to explain any "YES" answers or items that you marked in Section 2. You may attach additional sheets.

Question Number	Name	Diagnosis/Treatment	Diagnosis Date	Treatment Status

Section 3: Family Medications

YES NO Are you or anyone in your family applying for coverage currently taking any medications (including "over the counter" or "OTC" medicine) prescribed or recommended by a physician or practitioner?

If you answer "YES" to the question above, please use this table to explain. You may attach additional sheets.

Name	Medicine	Dosage & Frequency of Use	Date Prescribed	Date Last Taken or Ongoing	Condition(s) Being Taken For

PLEASE NOTE: If you leave out or misrepresent any information, the premium for your group coverage may change retroactive to the date the policy became effective. You or your authorized agent is entitled to receive a copy of this form.

Employee Signature: _____

Date Signed: _____

Black, Gould & Associates, Inc.

PRIVACY STATEMENT

Black, Gould & Associates, Inc. is proud to provide quality employee benefit products and services to our brokers and their customers. Keeping personal information secure and protecting individual privacy rights are important, and it is one of our top priorities.

This statement tells you about the information we request from Brokers and customers. It also tells you how we safeguard the personal information and protect the privacy rights of current and former customers.

Our Privacy Commitment to You

Black, Gould & Associates will safeguard personal information and protect the privacy rights of customers in accordance with state and federal laws. We will accomplish this in ways that are reasonable and consistent with sound business practices.

Protecting Your Health Information

We do not share personal health information (such as medical questionnaires) except when necessary to conduct underwriting reviews at the time of an Employer's initial enrollment through Black, Gould & Associates or upon an Employer requested underwriting review at a subsequent renewal. In certain circumstances, we may share personal health information if permitted or required by law.

Black, Gould & Associates is committed to protecting the confidentiality and security of private health information. We maintain physical, electronic, and process safeguards that restrict unauthorized access to individual personal health information. These security procedures include locked files and information system security measures such as user passwords, data encryption or firewall technology.

Black, Gould & Associates employees are required to comply with our policies and procedures to protect the confidentiality of individual personal health information. Any employee who violates our privacy policy is subject to a disciplinary process. Employee access to private information is limited on a business "need-to-know" basis such as: when necessary to conduct underwriting reviews, or for anonymous statistical analysis.

Information About Our Customers

Black, Gould & Associates receives information about customers in order to provide customer service, offer new products or services, administer products, and fulfill other legal and regulatory requirements. We will provide individuals with access to this information and the ability to review, amend, correct or copy this information, if we are required to do so under state law. The methods we use to protect this information are similar to those described above to protect health information.

The information we receive may vary by product; therefore, the examples that follow may not apply to all customers but are designed to show the general categories of information that may be received and maintained by Black, Gould & Associates:

- information provided by individuals on applications, forms, and our Web site, such as name, address, date of birth, Social Security number, gender, marital status and dependents.
- Information provided by the employer.
- Information about individual transactions and experiences with Black, Gould & Associates such as: products or services purchased, account balances, payment history, policy coverage, and premiums.

Information Shared With Others

We may disclose the personal information (not personal health information) we receive, as described above, to the following types of third parties:

- Other third parties as permitted or required by law, such as for compliance with a subpoena, fraud prevention, or inquiries from state or federal regulatory agencies.
- Financial service companies with whom we have agreements, such as: insurance companies, insurance brokers or agents, administrators, and service providers.

We maintain written contracts with third parties to help ensure that the personal information we share about customers is used for a legitimate business purpose.

Access and Amendment of Your Records

Individuals have the right to access and amend their records. They may exercise this right by requesting to us in writing to access and/or amend the records. Please send such requests to:

Privacy Office
Black, Gould & Associates, Inc.
3800 N. Central Avenue
9th Floor
Phoenix, Arizona 85012

Changes to Our Notice of Privacy Policy and Insurance Information Practices

We reserve the right to change our privacy policies and insurance information practices. If we make any changes to our policies or practices, we will provide you with a copy of a revised notice as required by applicable law.

Our Commitment

Black, Gould & Associates values our brokers and their customers, and we are committed to bringing you quality products and services. Our goal is to always use information in a responsible business manner. If there are state law requirements that prohibit sharing information without individual written permission, Black, Gould & Associates will comply with those requirements.

