

**HCC Life STM
Dependent Medical Questionnaire
For use in CA**



(Herein referred to as HCC Life)

Please complete this application entirely. Failure to provide complete information may delay processing.

Name (First and Last)	
Primary Applicant Name:	
Dependent Name:	
Dependent Date of Birth:	

Medical Questions	Please answer the questions below as they apply to the dependent named above.
1. Will the dependent have other health insurance in force on the policy effective date or be eligible for Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has the dependent: a. Been denied insurance due to any health reasons for a condition that is still? b. Now pregnant, in process of adoption or undergoing infertility treatment? c. Over 300 pounds if male or over 250 pounds if female?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the last 5 years has the dependent been diagnosed, treated, or taken medication for any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the last 5 years has the dependent been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. If the dependent is not a US Citizen, does he/she expect to legally reside in the US for the duration of the policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> US citizen
<p align="center">If you have answered "Yes" to questions 1 through 4 or "No" to question 5 above, coverage cannot be issued. Thank you for your interest. California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.</p>	

Authorization			
<p>I hereby request coverage under the insurance issued to the Consumer Benefits of America Association and underwritten by HCC Life Insurance Company. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that HCC Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.</p>			
Applicant Signature	Date	Spouse Signature	Date

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
	PBC 6CA.111.07.09	Code: