

Part 3: Medical history – Please answer all questions.

Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

Have you or any applying family member in the past 10 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner for any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 5.		YES	NO
1.	Brain or nervous system – such as: migraine headache; seizure disorder; loss of consciousness; epilepsy; paralysis; muscular dystrophy; multiple sclerosis; stroke; cerebral palsy; mental retardation?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Cardiovascular system – such as: heart or valve problems; coronary artery disease; heart attack; heart murmur; pericarditis; mitral valve prolapse; heart valve regurgitation; rheumatic fever; palpitations; high blood pressure; shortness of breath; chest pains; elevated cholesterol and/or triglycerides?	<input type="checkbox"/>	<input type="checkbox"/>
3.	Circulatory system – such as: varicose veins; peripheral vascular disease; phlebitis; blood clots; stroke; disease or disorder of the blood (except HIV infection); anemia; enlarged lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Respiratory tract – such as: asthma; reactive airway disease; bronchitis; allergies; sinusitis; disease, disorder or injury of the lungs or respiratory system; emphysema; tuberculosis; spitting or coughing up blood; shortness of breath; pneumonia; cystic fibrosis; pulmonary fibrosis; chronic obstructive pulmonary disease; sleep apnea? If asthma or allergies (circle frequency): daily, weekly, monthly, seasonal Severity (circle one): mild, moderate, severe, other	<input type="checkbox"/>	<input type="checkbox"/>
5.	A. Musculo-skeletal system – such as: pain, injury, sprain, or other problems of the neck, spine, or back; sciatica; herniated or bulging disc(s); curvature of the spine; scoliosis; pain, injury, or other problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis; temporo-mandibular joint syndrome (TMJ); Lyme disease; broken bones or retained hardware; dislocation of joints; bunions; hammertoe; carpal tunnel syndrome; physically handicapped; polio; amputations? B. If any chiropractic treatment has been received, please explain reason for treatment: _____ Number of chiropractic treatments within the past 6 months: _____	<input type="checkbox"/>	<input type="checkbox"/>
6.	Metabolic system – such as: diabetes; gout; thyroid or adrenal disorders; hormone or growth hormone deficiencies; immune system disorders (except HIV infection) such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or treatment for AIDS/ARC with AZT, HIVID, or Pentamidine therapy?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Cancer (malignancy) – such as: leukemia; Hodgkin's; malignant melanoma; tumor/cyst; lymphoma? Type: _____ If Yes, circle treatment type: chemotherapy, radiation therapy, other?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Congenital abnormalities, birth defects – such as: Down syndrome; cerebral palsy; cleft lip or palate; clubfoot; developmental delay; or other neurological or physical abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
9.	Alcoholism, drug dependency, or substance abuse? Type: _____	<input type="checkbox"/>	<input type="checkbox"/>
10.	Counseling or treatment for symptoms of depression; manic depression; anxiety; panic attacks; nervousness; mental or emotional disorders; schizophrenia; behavior problems; hyperactivity; attention deficit disorder; eating disorders; bulimia; anorexia; alcohol or substance abuse; or for any other reason? Are you currently in counseling? If yes, reason for counseling and frequency of treatment _____	<input type="checkbox"/>	<input type="checkbox"/>

Have you or any applying family member in the past 5 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner pertaining to any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 5.		YES	NO
11.	Male reproductive system – such as: prostate problems; impotency; male breast problems; gynecomastia; infections; herpes; syphilis; gonorrhea; or other venereal disease (except HIV infection); or is either the applicant, spouse, or domestic partner, whether or not listed on the application, being treated or been treated for infertility within the last 24 months?	<input type="checkbox"/>	<input type="checkbox"/>
12.	A. Female reproductive system – such as: breast problems; breast implants; adhesions; abnormal bleeding; amenorrhea; miscarriage and/or abortion; endometriosis; fibroid tumors; abnormal Pap test; problems of the ovaries, uterus, and associated female organs; in-vitro fertilization; infections, genital warts, herpes, syphilis, or other venereal disease (except HIV infection); or is either the applicant, spouse, or domestic partner, whether or not listed on the application, being treated or been treated for infertility within the last 24 months? Type of implants (circle one): saline or silicone B. Does any female applicant between the ages of 12 and 55 menstruate? 1. If yes, list the names of family member(s): _____; 2. Has it been more than 40 days since her/their last menstrual period? _____ 3. If Yes, list the names of family member(s): _____; 4. Please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
13.	Digestive system – such as: disease or disorder of the mouth, tongue, esophagus or stomach; ulcer; gall bladder disorder; liver disease; cirrhosis; jaundice; ascites; pancreatitis; colon, intestinal, or rectal problems; colitis; chronic diarrhea; hemorrhoids; hernia; weight or eating problems; hepatitis? If hepatitis, type(s): A, B, C, other	<input type="checkbox"/>	<input type="checkbox"/>
14.	Urinary tract – such as: renal colic; gravel or stones; urethra, bladder, ureter or kidney problems; urinary tract infections; stricture; pyelonephritis?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Skin conditions – such as: skin cancer; melanoma; psoriasis; keratosis; acne; herpes; warts; birthmarks; severe burns?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing – such as: any infections of eyes, ears, nose, or throat; crossed eyes; glaucoma; cataracts; detached retina; polyps; deviated nasal septum; excessive snoring; problems with tonsils or adenoids; sleep apnea?	<input type="checkbox"/>	<input type="checkbox"/>
17.	Abnormal laboratory results – such as blood work; X-rays; EKG; nerve conduction; blood flow studies; MRI, CT, PET, or other scans(s) (except HIV antibody detection tests)?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Prosthesis, implant, or retained hardware? Type: _____	<input type="checkbox"/>	<input type="checkbox"/>

Part 3: Medical history (continued) – Please answer all questions.

Remember to initial any changes/corrections you may have to make as you complete the questionnaire.

Have you or any applying family member in the past 10 years sought any professional consultation or received any treatment (including prescription medications) from a licensed health practitioner for any of the following?

All questions must be checked (✓) "Yes" or "No." Answer as completely and accurately as possible. Full details of any "Yes" answers must be given in Part 6.	YES	NO
19. Have you or any applying family member taken or been written a prescription for medication(s) in the last 12 months? If yes, please fill out Part 7 of this application.	<input type="checkbox"/>	<input type="checkbox"/>
20. In the past 5 years, have you or any applying family member:		
A. Been an inpatient or outpatient in a hospital, surgical center, sanitarium, or other medical facility, including an emergency room, or had surgery, including angioplasty, cosmetic/reconstructive, bypass, or transplant surgery?	<input type="checkbox"/>	<input type="checkbox"/>
B. Had any illness, physical injury, persisting or new physical symptoms and/or health problems not mentioned elsewhere on this application that have not been evaluated or that you plan to have evaluated by a licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
C. Been advised to have, or been referred for, a medical exam, further testing, treatment, or surgery that has not yet been performed by a physician, dentist, or other licensed health practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
D. Had any application for health or life insurance revoked, declined, deferred, postponed, or restricted in any way?	<input type="checkbox"/>	<input type="checkbox"/>
Family member: _____ Date: ____/____/____		
Please explain: _____		
21. Are you or any applying family member presently a member of a support group? Type: _____ How Long: _____	<input type="checkbox"/>	<input type="checkbox"/>
22. Males only: Are you expecting a child with anyone, even if the birth mother is not listed on the application?	<input type="checkbox"/>	<input type="checkbox"/>
23. Males and females: Is either the applicant, spouse, domestic partner, or dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
24. Have or do you or any applying family member:		
A. Requested or received a pension, benefits, or payment because of any injury, sickness, disability, or workers' compensation?	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoke(d) cigarettes? Family member: _____ How many packs per day: _____	<input type="checkbox"/>	<input type="checkbox"/>
C. Drink alcoholic beverages? Family member: _____ Number of drinks per week: _____	<input type="checkbox"/>	<input type="checkbox"/>
For how many years: _____ Have you/they stopped? _____ If yes, when? _____		

Part 4: Prior medical coverage- Please answer each question. If yes, please provide details in the space provided.

1. Did you or any applying family member have other health coverage (insurance) within the last 63 days?

Family member:	Yes	No	Type of coverage	Effective date	Cancel date:	Health plan carrier
Primary _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	_____	_____	_____
Spouse/DP _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Group <input type="checkbox"/> COBRA <input type="checkbox"/> Individual <input type="checkbox"/> Other	_____	_____	_____
Other: _____				_____		_____

Part 5: Medical condition details – If you answered “YES” to any of questions 1–24 with the exception of 19, 20D, 24B, and 24C in Part 3, give full details below for each condition.

If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, the section and the question number, as appropriate, include all information requested in Part 5 and **sign and date every attachment**. Check here for attachment.

List question number	Family member name and name used on doctor's records:	Diagnosis	Treatment:		
	First		Dates of treatment:		
	Last		Began: ____ / ____ (mm/yy) Ended: ____ / ____ (mm/yy)		
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Condition's present status			
Medical ID card # (if available)		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:		
Full name and address of every physician, clinic, or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.					
Name					
Phone number ()			Medical group		
Address:					Ste #
City				State	ZIP
List question number	Family member name and name used on doctor's records:	Diagnosis	Treatment:		
	First		Dates of treatment:		
	Last		Began: ____ / ____ (mm/yy) Ended: ____ / ____ (mm/yy)		
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Condition's present status			
Medical ID card # (if available)		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:		
Full name and address of every physician, clinic, or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.					
Name					
Phone number ()			Medical group		
Address:					Ste #
City				State	ZIP
List question number	Family member name and name used on doctor's records:	Diagnosis	Treatment:		
	First		Dates of treatment:		
	Last		Began: ____ / ____ (mm/yy) Ended: ____ / ____ (mm/yy)		
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Condition's present status:			
Medical ID card # (if available)		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:		
Full name and address of every physician, clinic, or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.					
Name		Phone number ()		Medical group	
Address					Ste #
City				State	Zip
List question number	Family member name and name used on doctor's records:	Diagnosis	Treatment:		
	First		Dates of treatment:		
	Last		Began: ____ / ____ (mm/yy) Ended: ____ / ____ (mm/yy)		
Does the condition still exist? <input type="checkbox"/> Yes <input type="checkbox"/> No		Condition's present status			
Medical ID card # (if available)		Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:	ER visits? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates:		
Full name and address of every physician, clinic, or hospital (include ZIP code). For physicians who belong to a medical group, please list the medical group as well.					
Name		Phone number ()		Medical group	
Address:					Ste #
City				State	ZIP

Part 6: List your health practitioner visits

Have you and/or any applying family member visited a physician, psychiatrist, chiropractor, physician assistant, nurse practitioner, physical therapist, or other licensed health practitioner in the past 5 years? If Yes, enter the details below. If No, check here and go to Part 4.

Note: Exams for children under 5 years of age are required. Medical Records will be requested for ALL children age seven (7) months and younger.

Name of applicant	Date of visit ____/____/____	Reason for exam	Results	Present status
Physician name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP
Name of spouse/domestic partner	Date of visit ____/____/____	Reason for exam	Results	Present status
Physician name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP
Name of dependent	Date of visit ____/____/____	Reason for exam	Results	Present status
Physician name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP
Name of dependent	Date of visit ____/____/____	Reason for exam	Results	Present status
Physician name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP

Part 7: Current or recent prescription medications

If you answered "YES" to question 19 in Part 3, please provide the details of the current and previous medications. If additional space is necessary to provide complete information, please attach an additional sheet of paper. Be sure to identify the family member, include all information requested and **sign and date every attachment**. Check here for attachment.

Name of family member		Dates from ____/____/____ to ____/____/____		
Medication	Reason for Rx	Dosage	Frequency	
Physician Name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP
Name of family member		Dates from ____/____/____ to ____/____/____		
Medication	Reason for Rx	Dosage	Frequency	
Physician Name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP
Name of family member		Dates from ____/____/____ to ____/____/____		
Medication	Reason for Rx	Dosage	Frequency	
Physician Name		Phone number	Medical group	Physician specialty
Address		Ste #	City	State ZIP

Part 8: Guaranteed issue

If you have recently concluded 18 months of creditable coverage without a significant break, you may be eligible for guaranteed issue of an individual plan directly from Blue Shield of California. You may contact Blue Shield of California directly to determine your eligibility for such coverage at 1-800-431-2809. Please note that "Guaranteed Issue" is not available through JACL Health Benefits Trust.

Part 9: Please read these conditions of membership and authorization and date and sign below

1. I (and my spouse/DP, if applying) am a current JACL member in a participating JACL Chapter and agree to maintain that JACL membership while covered under the JACL Health Benefits Administrators health plan I am applying for. I understand that Blue Shield has the right to decline my application. I understand that the cashing of my check by Blue Shield does not constitute approval of my application.
2. If my application is approved, Blue Shield will inform me of my effective date of coverage. As long as the JACL Health Benefits Administrators receives my first full dues payment before that date, I (and my family members, if applying and approved) will be covered as of that effective date of coverage. I understand that the effective dates of coverage of the Access+ HMO are always on the first day of the month.
3. If my application is approved, I understand that my application, including the Statement(s) of Health (Part 3-7), will become part of my health plan contract with Blue Shield.
4. If my application is approved for the Preferred (PPO) Plan, I understand that the plan provides substantially lower benefits when non-Preferred Providers are used. If my application is approved for the Access+ HMO plan, I understand that I (and my family members, if applying and approved) must select an HMO Personal Physician and that that HMO Personal Physician must provide or arrange for all my medical care. Please refer to the applicable Summary of Benefits booklet for a full explanation.
5. If the applicant is a minor, I will assume all responsibility for dues payments and for managing the provision of benefits under the plan applied for by my child. (Court documents must be attached authorizing guardianship if the responsible adult is not the parent).

6. Disclosure of Personal and Health Information

Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, "Blue Shield") understand the importance of keeping your and your dependents' personal and health information private. Blue Shield protects this information in electronic, written, and oral forms when used throughout our company. Blue Shield will not disclose this information without your authorization except as permitted by law.

For the purpose of administering your Blue Shield coverage, Blue Shield is permitted by state and federal law to obtain your and your dependents' health information from a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent. Also, by state and federal law, Blue Shield is permitted to disclose your and your dependents' health information to a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent.

A complete explanation of Blue Shield's policies and procedures ("Notice of Confidentiality and Privacy Practices") for preserving the confidentiality of your personal and health information is available and will be furnished to you upon request by calling the Customer Service Department or by accessing Blue Shield's web site.

Applicant's Social Security number

Other name under which applicant or family member has received care

Today's date (required)

X

Signature of applicant or legal guardian

Print name (and relationship if applicant is a minor)

Today's date (required)

X

Signature of applicant's spouse/DP (if applying)

Print name