



HEALTH APPLICATION COVER PAGE

Please take a moment to review the following tips before completing and returning your health insurance application and questionnaire:

1. Print clearly and complete the application in blue or black ink.
2. If you make any **changes** while completing this form (for example, you cross out something you wrote), be sure to **initial and date** those changes.
3. If any **corrections** are needed or if the form is incomplete, the application may have to be returned to you, or we may try to call you, to obtain the necessary information. In that case, we will record your information on a form that will be attached to your application.
Please Note: This may delay your effective date of coverage.
4. List the height and weight for each applicant.
5. List the date of birth for each applicant.
6. If you answered “yes” to any of the health history questions, please provide complete details in the section provided.

NOTICE OF MEMBER PROTECTION POLICY: You must provide truthful and complete answers to the following questions to the best of your ability. Failure to do so may impact your insurance coverage and will be a detriment to other farmers and agribusinesses that are members of the Farmers' Health Cooperative. If you are unsure of your current medical condition, we strongly recommend that you ask your current or previous physician(s) to clarify your specific condition. Our insurer has the right to review all of your medical records to verify accuracy of your information during the first 24 months you are covered. However, do not assume all of your medical records will be reviewed before approving your application.

Having sound policies and practices is critical to any insurance program, but especially to a member-owned and governed cooperative. If we issue coverage and later discover that you misrepresented or omitted information you knew in response to a question we may rescind your coverage, even after it has been issued. This means that you may lose your health benefits including coverage for treatment already received. Loss of coverage may occur even if we review your medical records or seek medical confirmation of your health information as part of processing your application. Even if you currently have health insurance coverage or had prior coverage, you must fully disclose and answer all health history questions. These policies are in place to protect all cooperative members.



ASA

Agri-Services Agency
Leaders in Agricultural Insurance



APPLICATION FOR INSURANCE – HEALTH QUESTIONNAIRE

Please list below all persons applying for coverage:

Name (First, middle initial, last)	Date of Birth	Height	Weight	Name (First, middle initial, last)	Date of Birth	Height	Weight

Please answer the following questions to the best of your knowledge. On the next page, please provide the complete details if you answer "Yes" to any of the questions.

1. Within the past 10 years, has anyone named in this application been counseled, consulted or treated for any of the following? (please check all conditions that apply):

CIRCULATORY SYSTEM

- a) heart disease or disorder Yes No
- b) stroke Yes No
- c) circulatory disorder Yes No
- d) chest pain Yes No
- e) high or low blood pressure Yes No
- f) elevated cholesterol and/or triglyceride levels Yes No
- g) anemia or blood disorder Yes No

DIGESTIVE SYSTEM

- a) ulcers Yes No
- b) stomach disorder Yes No
- c) liver/pancreas disorder Yes No
- e) intestinal disorder (ie. colitis, Crohn's disease) Yes No
- f) hernia Yes No
- g) rectal disorder Yes No

GENITOURINARY SYSTEM

- a) menstrual disorder Yes No
- b) genital disorder Yes No
- c) sexual dysfunction Yes No
- d) pregnancy complications (ie. premature birth, miscarriage, c-section) Yes No
- e) infertility Yes No
- f) urinary/tract/kidney/bladder disorder Yes No
- g) prostate disorder Yes No
- h) abnormal Pap smear results Yes No
- i) sexually transmitted disease or disorder Yes No

NERVOUS SYSTEM

- a) epilepsy or other seizures Yes No
- b) headaches Yes No
- c) multiple sclerosis Yes No
- d) disease or disorder of the brain Yes No

EYE OR EAR

- a) eye disorder Yes No
- b) ear disorder Yes No

BEHAVIORAL HEALTH

- a) attention deficit disorder Yes No
- b) psychological disorder Yes No
- c) suicide attempt Yes No
- d) eating disorder Yes No
- e) depression Yes No
- f) anxiety Yes No
- g) nervous, mental or emotional disorder Yes No
- h) nervous system disease or disorder Yes No

ENDOCRINE SYSTEM

- a) diabetes Yes No
- b) thyroid disorder Yes No
- c) adrenal disorder Yes No
- d) enlargement of the lymph-nodes Yes No
- e) connective tissue disorder Yes No
- f) elevated blood sugar Yes No
- g) sugar albumin or blood in urine Yes No

RESPIRATORY SYSTEM

- a) allergy(ies) Yes No
- b) asthmas Yes No
- c) emphysema Yes No
- d) sinus or nasal disorder Yes No
- e) lung disease or disorder Yes No
- f) shortness of breath Yes No
- g) hayfever Yes No
- h) pneumonia Yes No

MUSCULAR or SKELETAL

- a) arthritis Yes No
- b) fibromyalgia Yes No
- c) back disorder Yes No
- d) joint disorder Yes No
- e) musculoskeletal disorder Yes No
- f) skin disorder Yes No
- g) chronic fatigue syndrome Yes No
- h) acne Yes No
- i) throat disease or disorder Yes No
- j) paralysis Yes No
- k) spinal cord disorder Yes No

CANCER

- a) cancer Yes No
- b) tumor Yes No
- c) abnormal growth Yes No
- d) carcinoma in situ Yes No
- e) cyst Yes No
- f) polyp Yes No

OTHER

- a) organ or other type of transplant/implant Yes No
- b) breast disorder Yes No
- c) lupus Yes No
- d) abnormal mammogram results Yes No
- e) sleep disorder Yes No
- f) sleep apnea Yes No
- g) hepatitis Yes No

2. Have you, or has any person to be insured:

- a) smoked or used any tobacco product in the past twelve months? Yes No
- b) used drugs other than prescribed by a physician? Yes No
- c) been advised to have treatment or counseling for alcohol or drug abuse? Yes No

3. Are you, or is any person to be insured, now pregnant? No Yes Expected delivery date ____/____/____
 Single birth Multiple birth, number ____

4. Within the past ten years, has anyone named in this application had any other injury, illness or treatment for any condition not already listed; been hospitalized or scheduled for hospitalization; had any chronic condition for which you are not seeking active care but seek care on a routine monitoring basis; had surgery or had surgery scheduled; had a test or a test scheduled; or been recommended to have a test or surgery which was not performed for any reason not already mentioned in this application? (We are not seeking the results of HIV Antibody test) Yes No

5a. In the space below, please list and provide complete details if you answered "Yes" to any of the above questions. (Attach additional pages as necessary and sign the additional pages.) (Be sure to note the most recent readings for anyone with High/Low Blood Pressure, Elevated Cholesterol or Triglyceride levels or Glaucoma. Be sure to indicate frequency of visits and date of last visit for anyone receiving Behavioral Health counseling.)

Question #	Person Treated	Date(s) Treated		Illness or Health Condition (include diagnosis/prognosis)	Treatment Status (Ongoing, routine monitoring, resolved, etc.)
		Beginning	Ending		

5b. In the space below, please list all persons who are currently taking or have taken medication(s) within the past 10 years. (Attach additional pages as necessary and sign the additional pages.)

Person Taking Medication	Name of Medication	Dosage (mg) and Frequency (i.e. one pill per day)	Diagnosis (Reason for taking medication)	Date Prescribed	Date Discontinued

I hereby apply for coverage as indicated with Agri-Services Agency (ASA), with insurance coverage provided by Anthem. I understand that representations made herein will be used by ASA to determine final rates for my coverage. By signing below, I hereby authorize any physician, hospital, or other medical facility or professional to furnish to ASA, or its representatives, any medical record or information pertaining to me or any dependent family member in this application, even if it would otherwise be deemed confidential, on presentation of this authorization bearing my signature or a photocopy thereof.

Name of Applicant (please print): _____ Date: ____/____/____

Signature of Applicant: _____ Contact phone number (_____) _____

For questions please contact: ASA Sales/Service Center Phone: 1-800-654-8840 or Fax: 1-570-888-9197