Sample Application Questions – TriTerm Medical

For illustrative purposes only. Actual questions may vary by state and other factors. These are **not** the state-specific application questions. Applicants will be presented with state-specific questions during the application process.

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Application Questions			
General Information		**Yes**	**No**
G1	**During the past 12 months, has any applicant smoked cigarettes or e-cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
Other Coverage Information		**Yes**	**No**
O1	**Does any applicant have, or is any applicant currently applying for, other hospital or medical expense insurance that will not terminate prior to the requested effective date?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
If a question listed below under M1 through M6 is answered yes for any applicant, I understand that applicant will not be covered under the policy/certificate.			
Medical History Information		**Yes**	**No**
M1	**During the past 5 years, has any applicant been declined for insurance due to health reasons?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
M2	**Is any applicant currently pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
M3	**Is any applicant currently confined to a hospital, nursing home, mental facility, inpatient rehabilitation facility, subacute facility, or hospice?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
M4	**During the past 12 months, has any applicant:**		
	a. Been confined to a hospital (other than for pregnancy or routine newborn care), nursing home, mental facility, inpatient rehabilitation facility, subacute facility, or hospice? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	b. Experienced recurrent breast tumors, unexplained tumors/growths, or abnormal pap smear without normal follow-up pap smear? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	c. Experienced unexplained weight loss, fatigue, dizziness, or seizures? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	d. Experienced circulatory problems (such as vascular insufficiency), pulmonary hypertension, uncontrolled hypertension/high blood pressure, chest pains, irregular heartbeat or tachycardia? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	e. Received medical care from a member of the medical profession for a condition that has yet to be diagnosed? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	f. Been advised to undergo any test (except for HIV test), treatment, hospitalization, or surgery which has not yet been completed or for which results have not yet been received? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	g. Applied for, received, or currently receiving disability benefits from any insurance company, government, employer, or other source other than for maternity? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
M5	**During the past 5 years, has any applicant been advised by a doctor to seek treatment or been treated for substance use disorder, drug or alcohol abuse or addiction?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐

Application Questions *(continued)*

M6	**During the past 5 years, has any applicant been diagnosed with or received medical or surgical care from a member of the medical profession for any of the following:**		
	a. Disease or disorder of the heart or circulatory system, heart attack, cardiomyopathy, bypass/stent/angioplasty, atrial fibrillation, implant of pacemaker/defibrillator, renal hypertension, heart surgery (including valve replacement or correction), or congestive heart failure? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	b. Stroke/transient ischemic attack (TIA), thrombosis, embolism, or hemophilia? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	c. Chronic obstructive pulmonary disease (COPD) or any chronic lung disease, emphysema, cystic fibrosis, or pulmonary fibrosis? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	d. Diabetes (except gestational diabetes), organ transplant (or awaiting an organ transplant), bone marrow transplant, chronic kidney disease or disorder (not including stones), chronic liver disease including cirrhosis, hepatitis B, or hepatitis C? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	e. AIDS, HIV infection, or any AIDS related condition? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	f. Any cancer (excluding basal cell or squamous cell skin cancer), carcinoma in situ, leukemia, or Hodgkin's or non-Hodgkin's lymphoma? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	g. Paralysis, multiple sclerosis, muscular dystrophy, or amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	h. Systemic lupus erythematosus (SLE), Parkinson's, Alzheimer's, or senile dementia? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	i. Schizophrenia, bipolar mood disorder, mood (affective) disorder, or currently taking anti-psychotic medication prescribed by a medical professional? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	j. Crohn's disease or ulcerative colitis? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	k. Down's syndrome or cerebral palsy? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	l. Rheumatoid or psoriatic arthritis? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
	m. Autism or autism spectrum disorder? If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6	☐	☐
M7	**During the past 12 months, has any applicant been prescribed medications for any condition <u>not</u> listed above (excluding pregnancy)?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6 *(For each applicant responding yes, complete the "Prescription Medication Details" section that follows.)*	☐	☐
M8	**During the past 12 months, has any applicant been treated for, diagnosed with, or received medical or surgical care from a member of the medical profession, for any condition <u>not</u> listed above (excluding pregnancy)?** If yes, select each person: ☐Primary ☐Spouse ☐Child1 ☐Child 2 ☐Child 3 ☐Child 4 ☐Child 5 ☐Child 6 *(For each applicant responding yes, complete the "Medical Treatment Details" section that follows.)*	☐	☐

Prescription Medication Details

Person:_____

Medication Name	How Often Taken (e.g., daily)	Strength/Dosage (e.g., 20 mg)	Refill Frequency (e.g., monthly)	Condition or Symptom Treated	Date of Onset	Date Last Taken

Medical Treatment Details

Person:_____

Condition or Symptoms Treated	Date of Onset	Planned Surgeries, Ongoing Procedures, Testing or Treatments	Complete Recovery? (yes/no)