WEA trust
45 Nob Hill Road, P.O. Box 7338 | Madison, Wisconsin 53707-7338
800.279.4000 WEAtrust.com

WEA Trust Health Questionnaire

- **Please attach a separate sheet of paper if additional space is required.**
- **We will not seek individual medical records without first obtaining your authorization.**

1. Employer/Group Name: _____

2. Employee: _____ Residence Zip Code: _____

Date of Birth: ___/___/_____ ☐ Male ☐ Female Height: _____ Weight: _____

3. Please list all eligible individuals applying for Coverage:

Spouse/Domestic Partner: _____ ☐ Male ☐ Female DOB: ___/___/___ Height: _____ Weight: _____

Dependent: _____ ☐ Male ☐ Female DOB: ___/___/___ Height: _____ Weight: _____

Dependent: _____ ☐ Male ☐ Female DOB: ___/___/___ Height: _____ Weight: _____

Dependent: _____ ☐ Male ☐ Female DOB: ___/___/___ Height: _____ Weight: _____

Dependent: _____ ☐ Male ☐ Female DOB: ___/___/___ Height: _____ Weight: _____

4. In the last two (2) years, has anyone applying for coverage:

Incurred health care costs over $25,000 ☐ YES ☐ NO If YES, please explain in No. 6 below.

Had an inpatient hospital admission? ☐ YES ☐ NO If YES, please explain in No. 6 below.

5. In the last two (2) years, has anyone applying for coverage been treated for (*check all that apply*):

☐ Heart Disorder	☐ Diabetes	☐ Stomach Disorder
☐ Gallstones	☐ Kidney Disorder	☐ Thyroid Disorder
☐ Epilepsy	☐ Colitis	☐ Liver Disorder
☐ Paralysis	☐ Lung Disorder	☐ Cancer, Tumors, or Cysts
☐ Arthritis	☐ Disorders of the Blood	☐ Alcohol or Substance Abuse
☐ Behavioral Health	☐ Disorders of the Joints, Muscles, or Bones	

6. Please explain below for a "YES" in No. 4 and all checked items in No. 5:

Name of Person	Condition	Date of Onset	Degree of Recovery
1.			
2.			
3.			
4.			

continued on reverse

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(continued)

7. Are you or any dependent listed in No. 3 now disabled or unable to perform normal activities? ☐ **YES** ☐ **NO**

If YES, Name of Person: _____

Type of Disability: _____ Date of Disability: ___/___/___

8. Is anyone listed above currently pregnant? ☐ **YES** ☐ **NO** **If YES, due date:** ___/___/___

9. Please list all currently prescribed medications for you and all persons listed in question No. 3:

Name of Person	Name of Medication	Dosage per Day	Condition	Date First Prescribed
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /
				/ /

Attach separate sheet if additional space is required

10. Please give the names of the Doctors you use that are most important to anyone applying for coverage:

1. _____ 3. _____
2. _____ 4. _____

I, _____, hereby affirm the above statements to be accurate and complete.
(print name)

_____ _____
Employee Signature Date