



Health History Disclosure Form

Answer for yourself and every family member joining the plan. Takes about 10 minutes.

3 quick rules before you start

- Check Yes if you have the condition OR take a listed medicine — either one counts.
- Brand names are just examples — a similar drug for the same purpose still counts.
- An orange Rx tag means the medicine alone is enough to check Yes, even with no diagnosis.

Part A = right now or next 12 months. Part C = past 5 years or ongoing.

Part A — Current or Upcoming Treatment

Right now, or expected in the next 12 months.

Yes	No	Condition & medication	Rx
☐	☐	Cancer treatment (Excluding Basal Skin Cell Cancer). You're getting chemo, radiation, or other cancer treatment — including cancer pills taken at home, or pills taken to keep cancer from coming back. <i>Examples: Xeloda, Ibrance, tamoxifen.</i>	Rx
☐	☐	Biologic or specialty medication. You take an injected, infused, or specialty drug for any condition — or a medicine that suppresses your immune system. <i>Examples: Humira, Dupixent, Stelara.</i>	Rx
☐	☐	Organ failure or transplant. You need, or may soon need, an organ or bone marrow transplant.	
☐	☐	Home oxygen or ventilator dependency. You use supplemental home oxygen, a ventilator, or a BiPAP for a chronic respiratory condition.	
☐	☐	Gene or cell therapy. You're treated with gene or cell therapy for an inherited condition.	Rx
☐	☐	Kidney failure. You're on dialysis, or have advanced (Stage 4–5) kidney disease.	
☐	☐	Chronic pain requiring an implanted pump or spinal cord stimulator. You have an implanted device to manage severe, ongoing pain.	Rx
☐	☐	Lifelong bleeding disorder. You have hemophilia or a bleeding/clotting disorder you've had since birth.	Rx
☐	☐	Inpatient mental health / substance use care. You had a hospital stay, residential stay, or day program (Intensive Out Patient/Partial Hospitalization Program) for this.	
☐	☐	Regular infusion therapy for a rare, inherited, or complex chronic disease. You get scheduled infusions or specialty medicine to manage a rare or inherited disease. <i>Examples: Soliris, Cerezyme.</i>	Rx

Part B — Pregnancy and Fertility

For you, or anyone joining the plan, right now or currently underway within the next 12 months.

Yes	No	Question
☐	☐	Currently pregnant
☐	☐	Considering fertility preservation (egg or sperm freezing) in the next 12 months
☐	☐	Getting fertility treatment to become pregnant
☐	☐	Expecting a child through a partner's pregnancy, surrogacy, or adoption

Part C — Past 5 Years or Ongoing

Diagnosed, treated, or hospitalized in the last 5 years — or still ongoing.

Yes	No	Condition & medication	Rx
☐	☐	Heart or blood vessel condition. Heart attack, bypass, heart failure, stroke, irregular heartbeat, valve abnormalities (TAVR, Mitral Valve Clips), Watchman (LAAO/LAAC), a pacemaker or heart pump, blood thinners, or 3+ heart medications together. <i>Examples: Eliquis, Entresto, Xarelto, Lisinopril, Amlodipine, Lasix or similar.</i>	Rx

Yes	No	Condition & medication	Rx
☐	☐	Cancer. Any cancer (excluding Basal Cell Skin Cancer) — including pills taken by mouth, or medicine to keep it from returning. <i>Examples: tamoxifen, letrozole.</i>	Rx
☐	☐	Mental health condition. Schizophrenia, bipolar disorder, major depression, or anxiety needing ongoing care — or 2+ regular medications for it. <i>Examples: lithium, clozapine.</i>	Rx
☐	☐	Autoimmune condition. Your immune system attacks your own body — or you take immune-suppressing medicine or steroids for 3+ months. <i>Examples: lupus, MS, Crohn's, methotrexate.</i>	Rx
☐	☐	Type 1 diabetes. Including if diagnosed as an adult (sometimes called LADA) — or you use an insulin pump.	Rx
☐	☐	Chronic lung disease. COPD, cystic fibrosis, or similar — or a triple inhaler / biologic asthma shot. <i>Examples: Trelegy, Dupixent.</i> <i>Regular asthma inhalers alone don't count.</i>	Rx
☐	☐	Chronic liver disease. Cirrhosis, hepatitis B/C, or fatty liver disease with scarring.	
☐	☐	Blood or immune disorder. Sickle cell, hemophilia, aplastic anemia, HIV, or medicine for any of these. <i>Examples: Biktarvy, hydroxyurea.</i>	
☐	☐	Organ failure or past transplant. A past kidney, liver, lung, or heart transplant, or anti-rejection medicine. <i>Examples: tacrolimus.</i>	Rx
☐	☐	Ongoing organ support. You're on dialysis, ECMO, or an implanted heart pump.	
☐	☐	Recent hospital stay. A hospital stay in the last 5 years with ongoing care, including for mental health, substance use, or sepsis for the applicant, spouse, child, or any other dependent.	
☐	☐	Ongoing chronic pain, bone, joint, or muscle condition. Needs regular treatment such as injections for arthritis — back, neck issues, knee, shoulder, ankle, or joint replacement problems; therapy prior to joint replacement; Musculoskeletal Disorders such as but not limited to sciatica, osteoporosis, cervical/neck/back disorder (including any type of injection or procedure), Muscular Dystrophy, Cerebral Palsy, dermatomyositis, compartment syndrome.	
☐	☐	Substance use disorder. Alcohol or drug dependency, treated or not.	
☐	☐	Major surgery. In the last 5 years with ongoing care, or planned in the next 12 months.	
☐	☐	Brain or nerve disorder. Parkinson's, epilepsy, stroke, dementia, ALS, or similar.	
☐	☐	Reproductive or urologic condition requiring ongoing specialist care. Endometriosis, uterine fibroids, Peyronie's disease, or a similar condition treated by a specialist on an ongoing basis.	
☐	☐	Vision or hearing impairment requiring ongoing treatment or a device. Includes conditions requiring a hearing aid, cochlear implant, or ongoing treatment for significant vision loss (such as glaucoma or macular degeneration).	
☐	☐	Homebound or needs daily help. A condition that limits bathing, dressing, or feeding — or you're in hospice/palliative care.	
☐	☐		
☐	☐		

Part D — Data Participation

First two are required, the last are data collection questions.

Yes	No	Question
☐	☐	I consent to share health and consumer insights through periodic questionnaires
☐	☐	I am willing to join healthcare research studies
☐	☐	I am willing to participate in a personalized wellness coaching program
☐	☐	I am willing to complete an annual health screening (virtual or survey)
☐	☐	I am willing to share data from a wearable device or fitness tracker
☐	☐	Are you a diabetic on oral or injectable medications?
☐	☐	Have you been told to use a CPAP? If yes, "Do you use it daily when sleeping (or napping)?"
☐	☐	Do you have high blood pressure requiring 2 or more daily medications?

Yes	No	Question
☐	☐	Are you taking a GLP for weight loss? If yes, mark length 0-3 month, 4-6 months or >6 months.

Certification

By signing, I certify this information is true and complete for everyone listed above.

Signature

Date
