



Paramedical Examination For Group Coverage

Instructions

Proposed Insured

- The Examiner will document your medical history while asking you the questions in Section B and record the results of the examination on the back of the form.
- Review the information for accuracy and sign the Authorization (Section C) in the presence of the Examiner.

Note: The Examiner will send the completed form to Aetna Global Benefits.

Paramedical Examiner

- Ask the Proposed Insured the questions in Section B and document his/her medical history.
- Witness the Proposed Insured's signature in Section C. Your signature is also required.
- Complete the Examiner's Report on the back of the form relative to your findings after examining the patient.
- Return the Individual Paramedical Examination form to:

Aetna U.S. Healthcare
Medical Underwriting Department
66 Sigourney Street
Hartford, CT 06160-5000

Please Note: Be sure that all information in Sections A, B, and C is complete, particularly the Employee's Name and Social Security Number, and Control Number, and the Proposed Insured's Social Security Number (if applicable) and Birth Date.



Group Paramedical Examination

A. Employee Information

Employee Name (First, Middle Initial, Last)	Social Security Number	Contract Number
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B. Proposed Insured Information

Proposed Insured Name (First, Middle Initial, Last)	Birth Date (MM/DD/YYYY)	Social Security Number (if applicable)
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1. a. Name and Address of Your Personal Physician	b. Give date and reason last consulted
	c. What treatment was given or medication prescribed?

2. Yes <input type="checkbox"/> No <input type="checkbox"/>	Within the past 10 years, have you ever had or been treated for:	Give details of "Yes" answers. Identify question number, circle applicable items. (Include diagnosis, dates, durations, and names and addresses of all attending physicians and medical facilities.)
<input type="checkbox"/>	a. Disease of eyes, ears, nose or throat?	
<input type="checkbox"/>	b. Mental or nervous disease; dizziness, fainting, convulsions, headache, paralysis, stroke or other disease of the brain?	
<input type="checkbox"/>	c. Shortness of breath, persistent hoarseness or cough, asthma, emphysema, tuberculosis or other disease of the lungs?	
<input type="checkbox"/>	d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, high blood cholesterol, heart attack or other disease of the heart or blood vessels?	
<input type="checkbox"/>	e. Jaundice, hepatitis, cirrhosis, intestinal bleeding, ulcer, colitis, diverticulitis, hernia, hemorrhoids or other disease of the stomach, intestines, liver, gall bladder or pancreas?	
<input type="checkbox"/>	f. Sugar, albumin, blood or pus in urine; any disease of the kidneys, bladder, prostate, reproductive organs or breasts?	
<input type="checkbox"/>	g. Diabetes; thyroid, pituitary, adrenal or other endocrine diseases?	
<input type="checkbox"/>	h. Arthritis, gout, neuritis, sciatica or disease or injury of the muscles, bones or joints including the back and neck?	
<input type="checkbox"/>	i. Deformity or amputation?	
<input type="checkbox"/>	j. Acquired Immune Deficiency Syndrome or any AIDS-related disorders?	
<input type="checkbox"/>	k. Cancer, tumor, cyst, disease or skin or lymph glands?	
<input type="checkbox"/>	l. Allergies; anemia or other disease of the blood?	

3. <input type="checkbox"/>	a. Have you ever had any disorder of menstruation or pregnancy?
<input type="checkbox"/>	b. To your knowledge, are you now pregnant?

4. <input type="checkbox"/>	Are you now under observation or taking treatment?
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5. <input type="checkbox"/>	a. Do you use alcoholic beverage? If "Yes," give type, quantity and frequency.
<input type="checkbox"/>	b. Do you use prescription drugs? If "Yes," give type, dosage and frequency?
<input type="checkbox"/>	c. Have you ever received or been advised to have counseling for emotional or mental/nervous conditions?
<input type="checkbox"/>	d. Have you ever received or been advised to have counseling or treatment for alcohol or drug use?
<input type="checkbox"/>	e. Do you use tobacco products? (If they include cigarettes, indicate packs per day and number of years smoked.)

6. <input type="checkbox"/>	Other than the above, have you within the past 5 years:
<input type="checkbox"/>	a. Had a check-up, consultation, illness, injury or surgery?
<input type="checkbox"/>	b. Been a patient in a hospital, clinic or other medical facility?
<input type="checkbox"/>	c. Had electrocardiogram, x-ray or other diagnostic test?
<input type="checkbox"/>	d. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?

7. Family History: Include heart or kidney disease, high blood pressure, stroke, tuberculosis, diabetes, cancer, mental illness or suicide below.

	Living		Dead	
	Age	Health Status	Age	Cause of Death
Father				
Mother				
Brothers				
Sisters				

C. Authorization

The above answers and statements are true and complete to the best of my knowledge and belief.

Signed at _____ On _____

In the Presence of X _____ X _____

Signature of Examinee _____ Signature of Proposed Insured (Required)



Paramedical Examiner's Report

Aetna U.S. Healthcare

The Examiner should record the answers clearly and completely.

1. a.	Height (ft., in.)	Weight (lbs.)	Hair Color	Eye Color	Auscultation Heart -	Lang -
b.	Did you weigh? <input type="checkbox"/> Yes <input type="checkbox"/> No		Did you measure? <input type="checkbox"/> Yes <input type="checkbox"/> No			
c.	Weight gain (lbs.) in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No		Amount Gain (lbs.)	Amount Loss (lbs.)		
Cause						
d.	Are there any obvious physical or mental impairments? If "Yes," explain under Remarks. <input type="checkbox"/> Yes <input type="checkbox"/> No					
2. Blood Pressure (Record ALL readings. If history of hypertension or BP is 140/90 or higher, take 3 readings at 5 minute intervals.)						
Systolic - 1st _____		2nd _____		3rd _____		
Diastolic - 1st _____		2nd _____		3rd _____		
3.	Pulse (at rest)	Any obvious irregularities? <input type="checkbox"/> Yes <input type="checkbox"/> No		If over 90, retake after 5 minutes		
4. Urinalysis - Send Urine Specimen Test Results						
Specific Gravity -		Albumin -	Sugar -	Occult Blood -		
5. Specimen For Blood Profile - Send Results						
6. If EKG is Requested <input type="checkbox"/> We are mailing to: Aetna U.S. Healthcare, Medical Underwriting Department, 66 Sigourney Street, Hartford, CT 06160-5000						
7. Remarks or results of other tests or examinations. (For blood chemistry, give time of last food intake and time blood was drawn.)						

I certify that I examined the Proposed Insured in paramedical office or at _____
 on _____ at _____ a.m. p.m. _____
Street, Address, City, State, County

Paramedical Examiner's Name (Print Legibly)	Paramedical Examiner's Signature	Telephone Number ()
Paramedical Company		
Paramedical Local Office Address		

Mail promptly to: **Aetna U.S. Healthcare**
Medical Underwriting Department
66 Sigourney Street
Hartford, CT 06160-5000