WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
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. Is anyone listed on this questionnaire currently covered by Medicare? ☐ YES ☐ NO If YES, list name and reason for Medicare. _____

5. 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.

6. 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	

7. 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

WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

WEA Trust Health Questionnaire
(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