GLOBAL BENEFITS
INTERNATIONAL INSURANCE FOR EXPATS, TRAVELERS & ORGANIZATIONS

James D Smith
Global Benefits USA
james@gbusa.org
www.GlobalBenefitsUSA.com
USA: 888.541.7776
Abroad: +1 317 513 6706

Global Medical Insurance Questionnaire

SECTION 1. Please complete for all family members applying for coverage

NAME Please print your name below		HEIGHT	WEIGHT	DOB *mm/dd/yyyy*	COUNTRY OF CITIZENSHIP	GOVERNMENT ISSUED ID NUMBER
A. Applicant (last, first, middle)	☐ Male ☐ Female			___/___/____		
B. Spouse (last, first, middle)	☐ Male ☐ Female			___/___/____		
C. First child (below age 19 - last, first, middle)	☐ Male ☐ Female			___/___/____		
D. Second child (below age 19 - last, first, middle)	☐ Male ☐ Female			___/___/____		
E. Third child (below age 19 - last, first, middle)	☐ Male ☐ Female			___/___/____		

Residence address *(after this insurance becomes effective)*

Street address:

City:	State:	Country:	Postal/Zip Code:
Telephone:		Email:	
Fax:	**Is your expected length of residence outside the U.S. at least 6 of the next 12 months?** *(If a U.S. citizen and you answered "No," you are not eligible for coverage.)* ☐ Yes ☐ No		

U.S. Citizens / U.S. Nationals:

Date you did (or will) depart from the U.S.: ___/___/____ *mm/dd/yyyy*

Non-U.S. Citizens:

If a non-U.S. citizen, do you or any other applicant have a Green Card or U.S. visa? If yes, please complete the following:

a. Type of visa _____ **b.** Issue date ___/___/____

c. Expiration date ___/___/____ **d.** Date of arrival in U.S. ___/___/____

Green Card? ☐ Yes ☐ No

U.S. Visa ☐ Yes ☐ No

Mailing Address *(if different from above)*

Street address:

City:	State:	Country:	Postal/Zip Code:
Telephone:		Email:	
Fax:	**If either address above is in Florida, is the applicant currently located in Florida?** ☐ Yes ☐ No		

SECTION 2. Please answer all questions for the applicant and for each family member applying for coverage.

	If yes, show family member using letters from Section 1.
1. Are you or any other applicant currently disabled or unable to perform any activity of daily living?	☐ Yes ☐ No
2. Are you or any other applicant presently hospitalized, or scheduled for, in need of, or have been advised that you should have hospitalization or surgery?	☐ Yes ☐ No
3. Have you or any other applicant ever tested positive for, been diagnosed with, or been treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Lymphadenopathy Syndrome, Human Immunodeficiency Virus (HIV), or any other Immune System Disorder?	☐ Yes ☐ No
4. Have you or any other applicant ever had, been recommended to have, or are you currently on a waiting list for any organ transplant (other than corneal)?	☐ Yes ☐ No
5. Do you participate in professional sports or are you a commercial pilot?	☐ Yes ☐ No

If any individual answered YES to any of the above five questions, he or she does not qualify for this insurance. Thank you for your interest.

6. Have you or any family member applying for coverage ever applied for or purchased expat health insurance? (If yes: please provide details.)	☐ Yes ☐ No
7. Have you or any other applicant been diagnosed with or treated for any type of cancer or pre-cancerous condition during the past five (5) years? If yes, please explain in Section 3.	☐ Yes ☐ No
8. Are you or any other applicant currently pregnant? If yes, please provide due date: ___/___/____	☐ Yes ☐ No

For questions 9-29: Have you or any family member applying for coverage EVER experienced manifestation or symptoms of, suffered from, sought consultation for, examination, testing or been treated for, or been diagnosed with, any disease, condition, illness, medical problem, disorder, sickness, or other problem arising from, involving, or relating to any of the following:

9. Heart, cardiac, cardiovascular, and/or circulatory, including but not limited to: congestive heart failure, heart attack, angina, chest pain, arteriosclerosis, atherosclerosis, elevated blood pressure, hypertension, swelling of feet/ankles, thrombosis, phlebitis, rheumatic fever, or heart murmur? If yes, in addition to Section 3, please complete the following: a) Date of most recent blood pressure reading? ___/___/____ b) Most recent blood pressure reading: ☐ AS/ ☐ DS c) Medications taken (types and dosage)_____	☐ Yes ☐ No
10. Blood, blood vessels, spleen, arteries, veins, or disorders of the blood, including but not limited to: anemia, hemophilia, leukemia, hepatitis, lymph glands, or high cholesterol?	☐ Yes ☐ No
11. Diabetes, hyperglycemia or hypoglycemia? If yes to diabetes, in addition to Section 3, please complete the following: a) Diabetic Type: I ☐ or II ☐ b) Date diagnosed: ___/___/____ c) Controlled by diet only? Yes ☐ No ☐ d) Medications (types and dosage) _____ e) Date of most recent HbA1c Test? ___/___/____ f) Results of HbA1c Test (1 - 10)_____	☐ Yes ☐ No
12. Asthma or allergies? If yes, in addition to providing explanation in Section 3, please specify which one and complete the following: a) Date diagnosed: ___/___/____ b) Has hospitalization or emergency room treatment been required? If yes, describe and list date(s): ___/___/____ c) Please list known triggers: _____ d) Medications (types and dosage): _____ e) Frequency of attacks: _____	☐ Yes ☐ No
13. Cancer, tumor, cyst, polyp, melanoma, Kaposi's sarcoma, cell disorder, shingles, lump, calcification, or growth of any kind?	☐ Yes ☐ No
14. Liver, pancreas, gall bladder, or endocrine disorders including but not limited to: pituitary, thyroid, or metabolic disorders, or obesity?	☐ Yes ☐ No
15. Kidney, urinary tract functions, kidney, or bladder stones or infections?	☐ Yes ☐ No
16. Respiratory system including, but not limited to: tuberculosis, lung disorders, emphysema, chronic cough, bronchitis, bronchial asthma, pleurisy pneumonia?	☐ Yes ☐ No
17. Mental, emotional and/or nervous system disorders including but not limited to: psychosis, mental or behavioral disorders, ADD or ADHD, chemical or drug abuse or dependency, alcoholism, psychiatric counseling and/or support groups, depression, anxiety, chronic fatigue, or eating or sleeping disorders?	☐ Yes ☐ No

18. Neurological disorders, including but not limited to: multiple sclerosis (MS), muscular dystrophy, Lou Gehrig's disease (ALS), Parkinson's disease, paralysis, epilepsy, convulsions, seizures, migraines, chronic headaches, stroke, or transient cerebral ischemic attacks?	☐ Yes ☐ No	
19. Muscular, skeletal, spine, bone, or joint, including but not limited to: scoliosis, disc disease or disorder, vertebrae, degeneration, or any other back or neck condition, rheumatism, arthritis, gout, tendonitis, osteoporosis, or inflammation?	☐ Yes ☐ No	
20. For female applicants, miscarriage, complicated pregnancy or delivery, or infertility consultation, advice, and/or disorders of the reproductive system or of menstruation, including but not limited to: vaginal bleeding, fibroids, nodules or breast cysts, fallopian tubes, ovaries or uterus, and hormone replacement therapy?	☐ Yes ☐ No	
21. For male applicants, disorders of the reproductive system, including but not limited to: prostate or elevated PSA level, or erectile dysfunction?	☐ Yes ☐ No	
22. Congenital, genetic, hereditary or other birth condition or defect including but not limited to: mental retardation, Down Syndrome, or other chromosome disorder, physical disorder, deformity, or defect?	☐ Yes ☐ No	
23. Digestive system, stomach, colon, rectum, or intestines, including but not limited to: esophageal regurgitation, gastritis, ulcers, Crohn's Disease, and/or diverticulitis?	☐ Yes ☐ No	
24. Eyes, ears, nose, mouth, throat, or jaw, including but not limited to: cataracts, glaucoma, nasal septum deviation, chronic sinusitis, or TMJ?	☐ Yes ☐ No	
25. Do you or any family member applying for coverage currently use or during the past five years have used tobacco in any form?	☐ Yes ☐ No	
26. Any other disease, medical problem, illness, injury, or condition of any kind not listed above?	☐ Yes ☐ No	
27. During the last twelve (12) months, have you or any family member applying for coverage experienced manifestation or symptoms of, been diagnosed with, or received any consultation, examination, testing or treatment (including medications) for, any medical, health, mental, physical or nervous condition? If yes, please explain in Section 3.	☐ Yes ☐ No	
28. Have you or any family member applying for coverage ever been rejected, cancelled, rated, or declined for coverage under any health, life, or disability insurance policy? If yes, please explain in Section 3.	☐ Yes ☐ No	
29. During the last six (6) months, have you had comprehensive expat medical coverage? If yes, present additional fields to collect information: * Private insurance plan name: _____ * Insurer providing the plan: _____ * Coverage start date: ___/___/____ * Coverage end date: ___/___/____	☐ Yes ☐ No	

SECTION 2a. Please list all prescribed and over the counter medications, and any medical treatment in the last twelve months for the Applicant and for each Family Member for whom it applies (use the corresponding letter(s) from Section 1). Please attach additional pages as necessary.

Family Member *(Use letters from Section 1)*	Medications and Dosages	Conditions	Date(s) of Treatment *mm/dd/yyyy*
			___/___/____
			___/___/____
			___/___/____

Family Member *(Use letters from Section 1)*	Surgeries	Date(s) of Treatment *mm/dd/yyyy*
		___/___/____
		___/___/____
		___/___/____

Family Practitioner's Details - The following information must be completed

Doctor's Name:	Telephone:
Address:	
Country:	Postal/Zip Code:
Date Last Seen:	Reason:

SECTION 3. Medical Information

For any question answered "YES" in Section 2, please identify each family member for whom the answer applies (using the corresponding letter(s) from Section 1), and provide complete details of the medical condition at issue, including the name, address, and telephone number of the attending physician(s), hospital(s), clinic(s), and all other healthcare providers involved, diagnosis, all treatment dates, type(s) of treatment, prognosis, and present course of treatment. ***Please attach additional pages as necessary.***

Family Member *(Use letters from Section 1)*	Condition(s)/Diagnosis, Prognosis, Past and Present Course of Treatment(s)	Physician/Hospital/Clinic/Healthcare Provider Name(s), Address & Telephone	Date(s) of Treatment *mm/dd/yyyy*

If any family member applying for coverage has ever been rejected, cancelled, rated, or declined for coverage under any health, life, or disability insurance policy (see Question 28), please explain below.