FREEDOM CLAIMS MANAGEMENT, INC.

PO Box 1365, Great Bend, KS 67530 866-792-9151 www.freedomclaimsinc.com

Group Name: _____

To be completed, then sealed in the attached envelope and given to the designated employer representative. Note: The information contained herein is "protected health information" and must be kept confidential. This information will be used only for the purpose of obtaining a health insurance quote.

Employee:

Name:			SS#:
First	Middle	Last	
Address:			
Number and Street			
City	State		Zip
Phone:			Male: ☐ Female:☐
Home	Work		
Marital Status: Single: ☐		Married: ☐	

Dependents:

Dependent Name:	SS#	Relationship to Applicant	Date of Birth	Height	Weight

Health Information:

Important Notice: Any omissions or misstatements in this application may void your coverage or cause an otherwise valid claim to be denied.

Is anyone named in the application:

Currently pregnant? YES/NO If yes, due date_____

Currently taking any medication prescribed by a physician? YES/NO

Family Member	Name of Prescription	Name of Prescribing Dr.

Attach additional sheets if needed

Is anyone now disabled or unable to perform work or age related activities? YES/NO

Name _____ Date of Disability _____

Has anyone in this application had a professional medical diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? YES/NO

Within the last five years, has anyone named in this application been advised or scheduled to have surgery or tests not yet completed? YES/NO

Family Member	Surgery or Tests	Condition and Type of Treatment	Name of Physician

Within the last ten years had anyone named in this application been seen, counseled or treated for:

Heart Disease/Disorders, Stroke, Circulatory Disorder or High Blood Pressure	YES/NO	Headaches	YES/NO
Diabetes or Connective Tissue Disorder	YES/NO	Seizures, Epilepsy	YES/NO
Allergies, Asthma, Emphysema, Sinus, Nasal or Lung Disease or Disorder	YES/NO	Hernia, Rectal Disorder	YES/NO
Ulcers, Stomach or Intestinal Disorder	YES/NO	The Use of Alcohol, Chemicals or Other Drugs (Been Advised to Cease or Decrease Use Of)	YES/NO
Cancer, Tumor or Abnormal Growth	YES/NO	Anemia or Blood Disorder	YES/NO
Ear, Skin or Eye Disorder	YES/NO	Arthritis, Back, Joint or Muscle Disorder	YES/NO
Nervous Disorder (Including Attention Deficit and Psychological Disorder)	YES/NO	Liver Disorder	YES/NO
Menstrual or Gynecological Disorder or Infertility	YES/NO	Kidney, Bladder or Prostate Disorder	YES/NO
Thyroid, Adrenal Disorder or Enlargement of the Lymph-Nodes	YES/NO		

I have answered the above questions to the best of my knowledge and belief.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my family's health, to give Freedom Claims Management, Inc. such information. A photographic copy of this authorization shall be as valid as the original and valid from the date signed for the duration of one year.

_____ _____

Signature of Application Date Signed