

Colon Disorders Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. When was the diagnosis made? _____

2. Type of treatment _____

3. Hospitalizations _____

4. Surgery _____

5. Medications _____

6. Any previous or current colostomy? _____

7. Have you ever been treated with Prednisone or any other Steroid? _____

8. How frequent are your current symptoms? _____

9. When was the last time you were seen by a doctor for this condition? _____

Please be advised that you may be required to submit medical records.

Signature of Proposed Insured

Date

