AGC HEALTH PLAN
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Kidney Dialysis 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. What is the medical condition(s) that has been diagnosed? ____________________

   When did symptoms begin? __________________ Cause?____________________

2. What problems or symptoms have been experienced with this condition? ______________

   ____

   Last time they occurred?______________________________________

3. What treatment was received and when? Include any surgery, hospital stays and/or medication: ____

   ____

Medication name	Dosage	Frequency

4. How often do you visit the Dr.'s office or clinic for this condition?__________________

   When was the last visit and the recommendation? ____________________________

5. Have you, or are you currently receiving Dialysis? Yes or No If yes, what type of dialysis do you receive? Hemodialysis Peritoneal Other? ________________________

   How often do you receive dialysis treatment per week?___________________________

   Where do you receive the dialysis? Outpatient hospital, clinic, dialysis center, home?

   ____

6. What future tests, surgery or treatment have been recommended? ____________________

   ____

7. Do you expect to be, or are you on a waiting list for a kidney transplant? Yes or No

   If you are currently waiting, how long have you been on the list? ____________________

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

Employee signature: ______________________________________ Date: ____________