

Liver 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 specific medical condition(s) has been diagnosed? _____
When did it begin? _____ Cause _____
2. What symptoms occurred? Any current? _____
3. Any history of abnormal liver enzymes? If so, when and was treatment received?

Have they returned to normal? Yes or No How often are labs done? _____

Last date and results? _____

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

Medication name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Have you any history of, or are you now consuming alcohol? _____
Have you ever attended an alcohol rehabilitation program? _____
6. List any/all other medical conditions you are being treated for: _____
7. Are you a candidate for a future liver transplant? Yes or No If so, how long have you been on the waiting list? _____
8. Have future tests, surgery or treatment been scheduled, prescribed or recommended?
Yes or No If yes, please explain: _____

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

Employee signature: _____ Date: _____

