

Pregnancy Supplement 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: _____

A. Pregnancy due date: _____

B. Results of amniocentesis or ultrasound: _____

C. Explain any family history of hereditary/chromosomal disorders or history of previous newborns that experienced birth defects, previous blood transfusions, R.H. Negative Sensitization or other problems: _____

D. Explain any history of miscarriage, therapeutic abortion, stillbirth, premature birth, cesarean section delivery, or other complications of pregnancy: _____

E. Explain any difficulty, including vaginal bleeding, development of diabetes or hypertension, with this pregnancy: _____

F. Do you smoke? Yes No Number per day: _____

Applicant Statement:

I hereby agree that the statements in this supplement are true to the best of my knowledge and belief, and they shall form a part of any certificate or insurance which is issued.

Signature of Proposed Insured

Date

