AGC HEALTH PLAN
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Prostate 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. Name of prostate disorder ____________________
   If diagnosis was cancer, what stage? ____________________
   Age at diagnosis____________________
2. What are symptoms, i.e. night time voiding, difficulty voiding, other: __________
3. Was a prostate biopsy done? Yes or No When? ____________________
   Results?____________________
4. Are you currently taking medications or undergoing any form of treatment or therapy?
   If yes, give details: ____________________
5. Have future tests, surgery or treatment been scheduled, prescribed or recommended?
   If yes, give details: ____________________
6. Was PSA (Prostate specific antigen) done? Yes or No If so, what date and the level? ____________________

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

Employee signature: ____________________ Date: __________