

# Supplemental 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? \_\_\_\_\_

Location? \_\_\_\_\_ When did it begin? \_\_\_\_\_

2. Cause, if known: \_\_\_\_\_

3. What problems or symptoms have been experienced with this condition? Last time it happened? \_\_\_\_\_

4. Have any tests been done? Yes or No If yes, give test name, date and results: \_\_\_\_\_

5. How often does the person visit the Doctor's office or medical clinic for this condition \_\_\_\_\_ When was the last time and what was the result? \_\_\_\_\_

6. Have future tests, surgery, treatment, counseling been recommended or prescribed? If so, please explain: \_\_\_\_\_

7. Have you ever, or are you currently taking any medication for this or any other condition? If yes, please list:

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

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

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

