HEALTH PLANS
UNIVERSITY OF UTAH

QUOTING SHORT FORM

GROUP INFORMATION

Company Legal Name _____ DBA Name (if applicable) _____

ENROLLING MEMBER(S) INFORMATION

Relationship	Name	Gender (M/F)	Date of Birth

HEALTH INFORMATION

Please check the box below if you or any enrollment family member has received care of has pending care for the condition. For any box checked please explain treatment in boxes below.

- ☐ Alcohol Abuse
- ☐ Arthritis
- ☐ Back/Neck
- ☐ Blood
- ☐ Bone/Joint
- ☐ Brain
- ☐ Cancer/Tumor
- ☐ Diabetes
- ☐ Drug Abuse
- ☐ Epilepsy
- ☐ Ears/Nose
- ☐ Emphysema
- ☐ Heart Disease
- ☐ Infertility
- ☐ Intestines
- ☐ Kidney, Liver, Lungs
- ☐ Mental Illness
- ☐ Migraines
- ☐ Neurological
- ☐ Pancreas
- ☐ Skin
- ☐ Stomach
- ☐ Stoke
- ☐ STD / AIDS
- ☐ Other condition requiring surgery, home care, or hospitalization.

Name	Condition	Date(s) of Treatment	Treatment Required	Future Treatment Required

HEALTH INFORMATION *(Continued)*

Are you or an enrolling family member currently taking any medication not listed above? If so please complete the table below.

Name	Medication Name	Date(s) Taken	Condition

(1) The undersigned does hereby declare to the best of their knowledge and belief that the above answers, statements, and any attached information are accurate and complete. The undersigned also understands that failure to disclose information may constitute insurance fraud thereby subjecting them to potential prosecution.
(2) A photocopy of this form shall be as valid as the original.
(3) The undersigned also authorizes any care provider (person or institution) or other entity to provide any needed information to University of Utah Health Plans and/or TPAC Underwriters, Inc. It is therefore understood that this or any subsequently received information may be shared with any institution or person to which TPAC Underwriters, Inc. may reasonably see fit as it may become necessary as it complies with law.

Employee Name (Enrolling) _____

Employee Signature (Enrolling) _____ Date _____