



Herpes Questionnaire

Blue Cross Blue Shield of Georgia, Inc.
Attn: Underwriting Department
P. O. Box 13047
Roanoke, VA 24030
Customer Svc. Phone: 1-800-718-8831
Fax: 1-800-327-9255

Date: _____

Return by: _____

Underwriting Specialist: _____

Thank you for your application for health care coverage. To continue processing your application, please provide the following information by answering all the questions below. **(You may use additional paper if necessary. All additional sheets must be signed and dated by the applicant). PLEASE INITIAL AND DATE ANY ALTERATIONS.**

Concerning the diagnosis of Herpes for: _____

Name of person involved

- Please specify the type of Herpes: (please check one) Type 1 (fever blisters) Type 2 (genital) Ophthalmic (eyes)
 Other - **please specify:** _____
- When was this condition diagnosed? _____
- Indicate the last date of symptoms: _____ Last date of treatment: _____
- Specify any type of treatment/procedures, including dates: _____
- Was medication prescribed for this condition? Yes No **If yes, please complete the chart below:**

Name of Medication	Type of Medication (i.e. oral, injection, ointment)	Date Started (mm/dd/yyyy)	Date Stopped (mm/dd/yyyy) (If still taking, indicate "current". If taking whenever necessary, indicate "as necessary")

- Date of last physician visit related to this condition: _____ Reason for visit: _____
- Do you have any other conditions or symptoms related to this condition? Yes No **If yes, please explain:** _____

Certification

I certify that I have read or have had read to me this completed form. I understand that any answer or statement made on this form that is untrue and is material to the risk assumed by Blue Cross and Blue Shield of Georgia, Inc. may prevent the recovery of benefits under the policy and may also result in the termination or voiding of the policy back to its effective date. I understand that this form will now become part of my application for coverage with Blue Cross and Blue Shield of Georgia, Inc.

Signature of Applicant or Legal Representative

Date ____/____/____
mo. / day / year

Signature of Spouse or Other Adult to be covered
(if applying for coverage)

Date ____/____/____
mo. / day / year

An independent licensee of the Blue Cross and Blue Shield Association.