WELLFLEET

Last Name: _____ First Name: _____

Group #: _____

Insurance ID (located on your Insurance ID card): _____

Pre-existing Condition Questionnaire

Thank you for selecting the ISO Health Insurance Plan. Wellfleet is the claim administrator of your plan.

Please provide the condition/symptoms for which treatment was received_____

_____

Please provide the date when the symptoms related to this claim first began
(use MM/DD/YYYY format): _____/_____/_____

During the 12 months preceding your effective date of coverage have you consulted any physicians?

◯ Yes ◯ No

If yes, provide the name(s), address(es) and telephone number(s) of all doctor(s) consulted along with the date(s) of and reason(s) for the visit(s).

_____

_____

I authorize any physician, hospital, company, employer or organization to release the medical history, treatments or benefits payable for this claim to Wellfleet. A photocopy of this form shall be just as valid as the original. I certify that I have read all answers to this form, and to the best of my knowledge the information I have given is complete and true.

_____ _____

Signature Date

If you have any questions, please contact a member of our customer service team.

Please send response to:
Wellfleet Group, LLC
PO BOX 15369
Springfield, MA 01115-5369
Email: ISOclaims@wellfleet-iso.com
Phone: (855) 664-5837
Fax: (413) 452-5485