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Supplement to ConnectiCare® SOLO Application
MUSCULOSKELETAL QUESTIONNAIRE

Name of primary applicant: _____ ID/SSN: _____.

Name of person related to condition: _____.

1. Please check off all that apply:

- | | | |
|---|--|---|
| <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> DDD/DJD | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Radiculitis | <input type="checkbox"/> Spondylitis/Spondylolisthesis | <input type="checkbox"/> Tendonitis/Tenosynovitis |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Gout-Location: _____. |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Fracture/Broken bone | <input type="checkbox"/> Sciatica/Pinched nerve |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Carpel Tunnel Syndrome | <input type="checkbox"/> Osteoporosis/Osteopenia |
| <input type="checkbox"/> Rotator Cuff | <input type="checkbox"/> Polymyalgia/Myositis | <input type="checkbox"/> Other: _____. |

2. What was the date of diagnosis? _____. Date of last symptom? _____. What caused your condition? _____.

3. How are you being treated for this condition(check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Medication (name/dosage/frequency) | <input type="checkbox"/> Chiropractic care (dates/frequency) |
| <input type="checkbox"/> Physical therapy (dates/frequency) | <input type="checkbox"/> Other: _____. |

Please provide details to the treatments checked above:

_____.

4. Have you ever had or been advised to have surgery or spinal fusion? Yes or No: _____. If yes, please explain (dates, etc.): _____.

5. Do you require the use of cane, crutches or a wheelchair to move about? Yes or No: _____.

6. Have you ever had loss of time at work or restriction of activities? Yes or No: _____. If yes, please explain (dates, etc.): _____.

7. Has any further treatment or surgery been recommended? Yes or No: _____. If yes, please explain: _____.

8. Have you had a history of depression, anxiety or any other psychological condition not previously disclosed? Yes or No: _____. If yes, what was the diagnosis? _____. If any medications were required, please provide name, dosage and frequency taken: _____.

9. Have you completely recovered without any residuals or limitations? Yes or No: _____. If no, please explain: _____.

10. Please provide the names and addresses of the treating physicians for all conditions checked above: _____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my applicant for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): _____.

Today's Date: _____.

7/27/2009