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Supplement to ConnectiCare® SOLO Application
GYNECOLOGICAL SERVICES QUESTIONNAIRE

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

Name of person related to condition: _____.

1. Please check off all that apply:

- Abnormal Pap Smear/Mammogram Endometriosis Fibroid(s)
 Infertility PCOD/PCOS Cyst, lump, mass, nodule
 Ectopic pregnancy Abortion/miscarriage Menorrhagia/Metrorrhagia
 Cervical Cancer/Dysplasia Other: _____.

1. Date of diagnosis: _____.

2. Cause (if known): _____.

3. Date of last symptom: _____.

4. What type of treatment(s)/testing have you had or did you have?

<u>Procedure</u>	<u>Date</u>	<u>Results</u> (benign/malignant)
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. If you were prescribed medication, please provide the name, dosage, and frequency with which you took it or are taking it. _____.

7. Have you had a Mammogram/Pap smear since the original diagnosis or treatment? Yes or No: _____. If yes, when and what were the results: _____.

8. Name and address of the treating physician:

_____.

9. Do you have any plans for further treatment or surgery? Yes or No _____. If yes, please provide details. _____.

10. Have you completely recovered from this condition without residuals or limitations? Yes or No: _____. If no, please explain.
_____.

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 application 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