Dear Cigna-HealthSpring® Customer,

We are glad you have chosen us to be your health plan. We value you as a customer-and we want to help you stay as healthy as possible. One way we do this is by asking you a few questions about your health and lifestyle. We then work closely with your primary care doctor to make sure we give you the best possible care.

A quick survey about your health.

Below, you will find a few questions about your current health. By answering them, you can help us know how we can serve you better. It will only take about 10 minutes. If you are unable to fill it out, another person who knows about your health may help you.

Mark your answers by completely filling in the circle next to your answer.

Please use a dark blue or black ink pen when completing the survey. When you have finished answering the questions, please mail or fax the form to:

Cigna-HealthSpring Attn: HRA Department
500 Great Circle Road
Nashville, TN 37228
HRA Fax Number: 1-877-440-9340

The information you provide will be treated with absolute confidentiality and will help us learn more about you and your health needs. Information you provide may be reviewed by a care coordinator and health coach staff and will only be used to help your physician and other healthcare providers offer you high quality care.
Completion and submission of this form implies that you agree to have this information used for this purpose.

If you have any questions, please call one of our Health Risk Assessment Representatives at 1-800-331-6769 — they’ll be glad to help. TTY users may call 711.

Thank you for choosing Cigna-HealthSpring. We’re committed to getting you healthier.

Sincerely,

Health Risk Assessment Department

This information is available for free in other languages. Please call our customer service number at 1-800-668-3813 (TTY 711), seven days a week, 8 a.m. to 8 p.m. Esta información está disponible de forma gratuita en otros idiomas. Por favor, llame a nuestro servicio al cliente al 1-800-668-3813 (TTY 711), siete días a la semana, 8 a.m. to 8 p.m.

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Cigna-HealthSpring is contracted with Medicare for PDP plans, HMO and PPO plans in select states, and with select state Medicaid programs. Enrollment in Cigna-HealthSpring depends on contract renewal.
Today's date: ______________________
ID #: ___________________________
Name: _________________________
Address: ________________________

Please call Customer Service at
1-800-668-3813 (TTY 711)
to make address and/or phone
number changes.

General questions

1. What is your height? Feet
   ○ A) 3 ○ B) 4 ○ C) 5 ○ D) 6 ○ E) 7
   Inches ○ A) 0 ○ B) 1 ○ C) 2 ○ D) 3 ○ E) 4 ○ F) 5
   ○ G) 6 ○ H) 7 ○ I) 8 ○ J) 9 ○ K) 10 ○ L) 11

2. What is your weight? (Pounds (lbs))

3. In general, how would you rate your health?
   ○ A) Excellent ○ B) Very good ○ C) Good ○ D) Fair ○ E) Poor

4. Have you had a flu shot this year or are you planning to receive one this year? ○ A) Yes ○ B) No

When was the last time you had a:

5. Pneumonia vaccine? ○ A) In the last year ○ B) In the last 2-4 years ○ C) In the last 5 years ○ D) In the last 10 years ○ E) Never ○ F) Not applicable

6. Breast cancer screening (Mammogram)? ○ A) In the last year ○ B) In the last 2-4 years ○ C) In the last 5 years ○ D) In the last 10 years ○ E) Never ○ F) Not applicable

7. Colorectal cancer screening (Colonoscopy)? ○ A) In the last year ○ B) In the last 2-4 years ○ C) In the last 5 years ○ D) In the last 10 years ○ E) Never ○ F) Not applicable

8. Cervical cancer screening (PAP Smear)? ○ A) In the last year ○ B) In the last 2-4 years ○ C) In the last 5 years ○ D) In the last 10 years ○ E) Never ○ F) Not applicable

9. Do you exercise regularly or take part in a physical exercise program?
   ○ A) Yes, daily ○ B) Yes, more than 3 times a week ○ C) Yes, fewer than 3 times a week ○ D) No

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Your health

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10. What medical conditions do you have or have you had in the past? (Please indicate all that apply.)

○ A) Anxiety  ○ H) Depression  ○ O) Schizophrenia
○ B) Asthma  ○ I) Diabetes  ○ P) Stroke
○ C) Bi-polar disorder  ○ J) Hearing problems  ○ Q) None
○ D) Cancer  ○ K) Heart failure  ○ R) Vision problems
○ E) COPD/emphysema  ○ L) Hypertension  ○ S) Other
○ F) Coronary heart disease  ○ M) Organ transplant
○ G) Dementia  ○ N) Renal/kidney failure

11. Which of the following are you currently receiving treatment for? (Please indicate all that apply.)

○ A) Anxiety  ○ H) Depression  ○ O) Schizophrenia
○ B) Asthma  ○ I) Diabetes  ○ P) Stroke
○ C) Bi-polar disorder  ○ J) Hearing problems  ○ Q) None
○ D) Cancer  ○ K) Heart failure  ○ R) Vision problems
○ E) COPD/emphysema  ○ L) Hypertension  ○ S) Other
○ F) Coronary heart disease  ○ M) Organ transplant
○ G) Dementia  ○ N) Renal/kidney failure


13. How many medications do you take?  ○ A) 0  ○ B) 1-3  ○ C) 4-5  ○ D) 6-7  ○ E) 8+

14. Do you find that you sometimes have to choose between buying groceries or medications?  ○ A) Yes  ○ B) No

15. Have you fallen in the past 6 months? (A fall is when your body goes to the ground without being pushed.)  ○ A) Yes  ○ B) No

16. In the past 3 months, how many times did you go to the Emergency Room?

○ A) 0  ○ B) 1  ○ C) 2  ○ D) 3 or more

17. In the past 6 months, how many times have you had unplanned overnight stays as a patient in a hospital?

○ A) 0  ○ B) 1  ○ C) 2  ○ D) 3 or more

18. Has your doctor recently told you that you need to lose weight?  ○ A) Yes  ○ B) No

19. Are you on a special diet recommended by your doctor (low sodium, low cholesterol, low fat)?  ○ A) Yes  ○ B) No

20. In the past 7 days, how many servings of fruits and vegetables did you typically eat each day? (1 serving = 1 cup of

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In the past 7 days, how many servings of fried or high-fat foods did you typically eat each day? (Examples include fried chicken, fried fish, bacon, French fries, potato chips, corn chips, doughnuts, creamy salad dressings, and foods made with whole milk, cream, cheese, or mayonnaise.)

- A) 0
- B) 1
- C) 2-3
- D) 4+

In the past 7 days, how many sugar-sweetened (not diet) beverages did you typically consume each day?

- A) 0
- B) 1
- C) 2-3
- D) 4+
34. Have you ever felt guilty or badly about your drug or alcohol use?  
   ○ A) Yes  ○ B) No  ○ C) Not applicable

35. Have you ever used drugs to ease withdrawal symptoms, or to avoid feeling low after using drugs or alcohol?  
   ○ A) Yes  ○ B) No  ○ C) Not applicable

36. Have you ever been treated for drug or alcohol abuse?  
   ○ A) Yes  ○ B) No  ○ C) Not applicable

37. In the past 4 weeks, how much body pain have you had?  
   ○ A) None  ○ B) Mild  ○ C) Very mild  ○ D) Moderate  ○ E) Severe  ○ F) Very severe

38. During the past 4 weeks, how much did pain interfere with your normal activities?  
   ○ A) Not at all  ○ B) A little bit  ○ C) Moderately  ○ D) Quite a bit  ○ E) Extremely

39. During the past 4 weeks, how has your health impacted your ability to work or caused you to be absent from activities you enjoy?  
   ○ A) Not at all  ○ B) A little bit  ○ C) Moderately  ○ D) Quite a bit  ○ E) Extremely

Do you need help doing the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Standing up from a sitting position?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>42. Walking outside of the house?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>44. Eating a meal?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>46. Bathing?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>48. Organizing your day?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>41. Walking in the house?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>43. Preparing a meal?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>45. Getting dressed?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>47. Using the toilet?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
<tr>
<td>49. Driving or getting to places?</td>
<td>○ A)</td>
<td>○ B)</td>
</tr>
</tbody>
</table>

50. If you answered “Yes” to any of the above questions, do you have someone who can assist you?  
   ○ A) Yes  ○ B) No

51. How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?  
   ○ A) Always  ○ B) Usually  ○ C) Sometimes  ○ D) Never

52. In the past 2 weeks, have you experienced a significant change in the amount you normally sleep, either trouble getting to sleep or sleeping too much?  
   ○ A) Yes  ○ B) No
Advanced care planning

53. Do you have a Medical Power of Attorney? (Someone to make medical decisions for you in the event you are unable to)  
   A) Yes  B) No  C) Don’t know/don’t remember

54. Do you have a living will/advance directive? (Documents that make your health care wishes known)  
   A) Yes  B) No  C) Don’t know/don’t remember

55. Is a copy of your advance directive on file at your doctor’s office?  
   A) Yes  B) No  C) Don’t know/don’t remember

About you

My health is important to me.  

<table>
<thead>
<tr>
<th></th>
<th>Strongly disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>56. I am ultimately the one responsible for taking care of my health and wellness.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
<tr>
<td>57. It is important for me to take an active role in my health care.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
<tr>
<td>58. I am confident I can prevent or reduce problems associated with my health.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
<tr>
<td>59. I am confident I know when I need to seek medical care and when I am able to take care of myself.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
<tr>
<td>60. I am confident I can talk to my doctor about my health concerns even when he or she does not ask.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
<tr>
<td>61. I am confident I can follow through on medical treatments I may need to do at home.</td>
<td>A)</td>
<td>B)</td>
<td>C)</td>
<td>D)</td>
</tr>
</tbody>
</table>

62. Who completed this survey form?  
   A) Myself  B) Relative of mine  C) Friend of mine  D) Professional caregiver of mine

63. Do you live?  
   A) Alone  C) With other family member  E) Nursing home or assisted living facility  
   B) With Spouse  D) With non-relative

64. What is your primary Language?  
   A) English  B) Spanish  C) Other

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65. What is the highest grade or level of school that you completed?

- A) 8th grade or less
- B) Some high school, but did not graduate
- C) High school graduate or GED
- D) Some college or 2 year degree
- E) 4 year college graduate
- F) More than a 4 year college degree

66. What is your ethnicity?

- A) African American
- B) Native American
- C) Hispanic
- D) Native Hawaiian
- E) Indian
- F) Asian
- G) Caucasian
- H) Pacific Islander
- I) Other

67. Do you ever choose not to seek medical care because of religious or personal beliefs?

- A) Yes
- B) No
- C) Prefer not to answer

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