

FAMILY HEALTH STATEMENT

CHECK ONE: New Group

New Employee Add

Existing Employee Change

PRINT IN INK---COMPLETE BOTH SIDES OF FORM

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER:		EMPLOYER ADDRESS:	
POLICY NUMBER		Street:	
APPLICANT'S OCCUPATION		City:	
HOURS WORKED/WEEK		ST/Zip:	
		DATE OF FULL TIME HIRE	

TO DECLINE COVERAGE -- EMPLOYEE IS TO COMPLETE THIS AREA

() **DECLINE** TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE FOR: MYSELF () SPOUSE () DEPENDENT CHILDREN ()

If I and/or my dependents decline coverage and desire to participate in the plan at a later date, I may have to submit evidence of insurability satisfactory to the insurance company.

SIGNATURE OF EMPLOYEE:

DATE:

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS

IF ADDITIONAL SPACE IS NEEDED, ATTACH SEPARATE SHEET -- COMPLETE FOR ALL FAMILY MEMBERS APPLYING FOR COVERAGE

FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH MM/DD/YYYY	SEX M/F	FULL TIME STUDENT Yes/No-If yes, Name School
EMPLOYEE:							
SPOUSE:							
EMPLOYEE SOCIAL SECURITY NUMBER:			MARITAL STATUS: () SINGLE () MARRIED				
EMPLOYEE ADDRESS: Street:			PHONE: WORK () - HOME () -				
City:			WHERE WOULD YOU PREFER TO BE CALLED DURING THE DAY?				
ST/Zip:			() HOME () WORK				

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations, or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding, or reformation of insurance.

DATE: _____ **Employee Signature:** _____ **Spouse Signature:** _____

OTHER SIDE MUST BE COMPLETED

EMPLOYER NAME: _____

(please print)

- ARE YOU NOW ACTIVELY AT WORK FULL TIME (30+ HRS/WEEK)? () YES () NO
 ARE YOU NOW ACTIVELY AT WORK 20-29 HRS/WEEK? () YES () NO
 DOES YOUR SPOUSE HAVE MEDICAL COVERAGE ELSEWHERE? () YES () NO
 IS ANY PERSON TO BE INSURED CURRENTLY COVERED UNDER COBRA? () YES () NO
 IS ANY PERSON TO BE INSURED ENROLLED IN MEDICARE? () YES () NO

IF YES, WHO: _____ () MEDICARE A () MEDICARE B

TO REQUEST COVERAGE--ANSWER ALL QUESTIONS DETAILS MAY BE SUBMITTED VIA SEALED ENVELOPE MARKED "CONFIDENTIAL"
FOR "YES" ANSWERS, DETAILS MUST BE PROVIDED IF ILLNESS IS UNLISTED. PROVIDE DETAILS IN THE ROW MARKED "OTHER"

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities?
WHO: _____ WHY: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason?
WHO: _____ WHY: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason?
WHO: _____ WHY: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you, or any dependent to be covered, currently pregnant?
WHO: _____ EXPECTED DELIVERY DATE: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is this pregnancy the result of infertility treatment?
Please explain: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you, or any dependent to be covered, currently taking any medication?
WHO: _____ MEDICATION: _____
WHY: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you, or any dependent, had medical expenses in excess of \$5,000.00 in the last 12 months?
WHO: _____ WHY: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you, or any dependent ever had, or has a Medical Professional told, counseled, or treated, you or any dependent, for any of the following?
In answering this question, you should not include any genetic information. Please do not include any family medical history information
(other than the specific information requested below) or any information related to genetic services or genetic diseases for which you believe you may be at risk. | <input type="checkbox"/> | <input type="checkbox"/> |

	Person Affected		Diagnosis & Date Diagnosed	Treatment And/or Medication	Degree of Recovery	Name, Address & Phone Number of Physician and/or Hospital
	YES	NO				
a) Chest Pain, Heart Attack, or other heart condition	<input type="checkbox"/>	<input type="checkbox"/>				
b) Condition/Disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)	<input type="checkbox"/>	<input type="checkbox"/>				
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)	<input type="checkbox"/>	<input type="checkbox"/>				
d) Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)	<input type="checkbox"/>	<input type="checkbox"/>				
e) High Blood Pressure (if yes, provide most recent reading)	<input type="checkbox"/>	<input type="checkbox"/>				
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)	<input type="checkbox"/>	<input type="checkbox"/>				
g) Alcohol or drug use, abuse, and/or dependency	<input type="checkbox"/>	<input type="checkbox"/>				
h) Disease of the kidney, bladder or urinary tract	<input type="checkbox"/>	<input type="checkbox"/>				
i) Crohns, Colitis, diseases of stomach, intestine, esophagus or gallbladder	<input type="checkbox"/>	<input type="checkbox"/>				
j) Disorder of the liver or pancreas	<input type="checkbox"/>	<input type="checkbox"/>				
k) Disorder of the lungs or respiratory system	<input type="checkbox"/>	<input type="checkbox"/>				
l) Organ Transplants (if yes, include type and date)	<input type="checkbox"/>	<input type="checkbox"/>				
m) Neurologic problems--disorder of the brain, seizures, epilepsy, central nervous system--stroke or paralysis	<input type="checkbox"/>	<input type="checkbox"/>				
n) Nervous, mental, depression, stress or anxiety related disorder, eating disorder	<input type="checkbox"/>	<input type="checkbox"/>				
o) Disorder of the blood (including anemia)	<input type="checkbox"/>	<input type="checkbox"/>				
p) Lupus or Arthritis (if yes, indicate type and severity of disability)	<input type="checkbox"/>	<input type="checkbox"/>				
q) Congenital anomalies or disorders	<input type="checkbox"/>	<input type="checkbox"/>				
r) OTHER (any disease/condition not listed above)	<input type="checkbox"/>	<input type="checkbox"/>				