FAMILY HEALTH STATEMENT

CHECK ONE: New Group ☐ New Employee Add ☐ Existing Employee Change ☐

PRINT IN INK----COMPLETE BOTH SIDES OF FORM

Information provided on this form will have no effect on nor be considered when calculating premiums and/or cost sharing and will not affect your eligibility for coverage. This information is provided so that your health insurance plan can better manage potential adverse health issues and assist you in preventing or managing chronic health conditions you may have or which you may have the potential of developing.

TO BE COMPLETED BY EMPLOYER

NAME OF EMPLOYER:	EMPLOYER ADDRESS: Street:
POLICY NUMBER	City:
	ST/Zip:

APPLICANT'S OCCUPATION	HOURS WORKED/WEEK	DATE OF FULL TIME HIRE

TO DECLINE COVERAGE -- EMPLOYEE IS TO COMPLETE THIS AREA

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

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:					
CHILD(REN)					

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.

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:		
2.	Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? WHO: WHY:		
3.	Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? WHO: WHY:		
4.	Are you, or any dependents to be covered, currently pregnant? WHO: EXPECTED DELIVERY DATE		
5.	Is this pregnancy the result of infertility treatment? Please explain:		
6.	Are you, or any dependents to be covered, currently taking any medication? WHO: _____ MEDICATION:_____ WHY:_____		
7.	Have you, or any dependent, had medical expenses in excess of $5,000.00 in the last 12 months? WHO: WHY:		

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.

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