



**Statement of Health**  
for large group eligible employees



Last Name	First Name	SSN or HICN #	Telephone Number	Employer/Group Name
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This Statement of Health is designed to provide information specific to you and your dependents applying for coverage under the Enrollment Application.

I hereby acknowledge and agree that the information provided in this Statement of Health is complete, true and correct to the best of my knowledge for me, and my dependents enrolling in this health plan. If accepted for coverage, any misrepresentation or omission in answering these questions may result in (i) rescission of coverage to the coverage effective date; (ii) termination of coverage, or (iii) subject to underwriting guidelines at the Plan's discretion.

Please provide the health history of you and your dependents applying for coverage on this application. Please CHECK all applicable Yes/No responses, CIRCLE specific condition(s) for which you answer "Yes" and provide corresponding details in the appropriate section.:

**Section 1. Please answer fully and accurately. Incomplete answers could delay the processing of your Enrollment Application.**

	YES	NO
1. Have you or any dependent been diagnosed, treated or advised to have treatment by a medical professional for any of the following conditions, including but are not limited to the following: Do you or anyone who will be covered on this policy have Alcohol or Drug Abuse, Arthritis, Birth defects, Bleeding or Clotting disorders, Cancer, Diabetes, disorder of the neck/back/spine, Heart conditions, intestinal, Kidney (Dialysis, Failure, Stones, etc.), Liver (Cirrhosis, Hepatitis B, C or D), Lung conditions, Organ transplant, Stroke, Tumors, Vascular (blood vessel) disorders, or current tobacco use? (Please give details below).		
2. Have any eligible employee or dependent ever tested positive for human immunodeficiency virus (HIV) or been diagnosed as having aids related complex / conditions (ARC), acquired immunodeficiency syndrome (AIDS) or any other medical condition / disorder derived from such infection or immunodeficiency? (Please give details below).		
3. Have you or anyone to be covered on this policy, had any future surgery or medical treatment discussed, planned or recommended? (Please give details below).		
4. During the last 24 months, have you or anyone who will be covered on this policy, had surgery or been admitted to any hospital or any other medical facility? (Please give details below).		
5. Are you or anyone who will be covered on this policy currently pregnant? If "YES", due date: _____ (MM/YEAR)		
6. Are you or anyone who will be covered on this policy currently taking any prescription medications? (Please give details below to include the name of the medication and condition for which the medication is needed)		
7. Do you, or anyone who will be covered on this policy, have any medical condition, which has not yet been disclosed? (Please give details below).		

**Section 2. Provide details in the space below for all answers checked "Yes" or circled answers above. If necessary, attach additional pages detailing the same information requested below. You or the applicable dependent must date and sign any additional pages.**

Question Number	Person's Name	Condition (Include start date of condition)	Types of Treatment (Month/Year)	Medications (oral, injectable, infusion or inhaled)	Is ongoing treatment needed? If "Yes", please explain:

I certify that all information and statements furnished by me are true and complete to the best of my knowledge. I am duly authorized to execute this Statement of Health.

**Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.**

Employee Name: \_\_\_\_\_  
(Please Print)

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Dependent Signature: \_\_\_\_\_  
(if over 18)

Date: \_\_\_\_\_

Dependent Signature: \_\_\_\_\_  
(if over 18)

Date: \_\_\_\_\_