Family Health Statement

Check one: ☐ New group ☐ New employee add ☐ Existing employee change

Print in ink – complete both sides of form

SECTION 1: TO BE COMPLETED BY EMPLOYER

Employer name			Policy no.
Employer street address	City	State	ZIP code
Applicant occupation	Hours worked per week		Full-time hire date

SECTION 2: EMPLOYEES – Only complete this section if you do not want coverage

I do not want this health insurance. I have other health insurance coverage for:

☐ Myself
☐ Spouse
☐ Dependent children

If I, and/or my spouse and dependents want to participate in this plan at a later date, I understand that I may have to submit evidence of insurability satisfactory to the insurance company.

Employee signature (sign here only if you do not want health insurance coverage)	Date
X	

SECTION 3: EMPLOYEES – Complete this section if you are requesting coverage

Last name	First name	M.I.	Height	Weight	Birthdate MM/DD/YYYY	Sex	Full-time student / If yes, name of school
Employee						☐ M ☐ F	☐ Yes ☐ No
Spouse						☐ M ☐ F	☐ Yes ☐ No
Dependent						☐ M ☐ F	☐ Yes ☐ No
Dependent						☐ M ☐ F	☐ Yes ☐ No
Dependent						☐ M ☐ F	☐ Yes ☐ No
Dependent						☐ M ☐ F	☐ Yes ☐ No

Employee Social Security no.	Marital status ☐ Single ☐ Married	Home phone ( )	Work phone ( )	Where would you prefer to be called during the day? ☐ Home ☐ Work

Employee street address	City	State	ZIP code
Employee email address			

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.

Employee signature	Spouse signature	Date
X	X	

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Employer name

- Are you now actively at work full time (30+ hours per 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: ☐ Part A ☐ Part B

SECTION 4: EMPLOYEES — Complete this section if you are requesting coverage

You may send this form in a sealed envelope marked "CONFIDENTIAL".
Include details for all "Yes" answers.
For an illness not listed, provide details in the last row marked "OTHER".

1. Are you, your spouse, or any dependent to be insured, currently disabled or unable to perform their normal activities? ☐ Yes ☐ No
   Who: Why:
2. Have you, or any dependent, been hospitalized, or been advised to be hospitalized within the past 5 years for any reason? ☐ Yes ☐ No
   Who: Why:
3. Have you, or any dependent, had surgery, or been advised to have surgery within the past 5 years for any reason? ☐ Yes ☐ No
   Who: Why:
4. Are you, or any dependents to be covered, currently pregnant? ☐ Yes ☐ No
   Who: Expected delivery date: ______/______/______
5. Is this pregnancy the result of infertility treatment? ☐ Yes ☐ No
   If yes, please explain:
6. Are you, or any dependents to be covered, currently taking any medication? ☐ Yes ☐ No
   Who: Medication: Why:
7. Have you, or any dependent, had medical expenses in excess of $5,000 in the last 12 months? ☐ Yes ☐ No
   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? ☐ Yes ☐ No
   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 and date diagnosed	Treatment and/or medication	Degree of recovery	Name, address and phone no. of physician and/or hospital
a) Chest pain, heart attack, or other heart condition	☐ Y ☐ N					
b) Condition/disease of the circulatory system (i.e. blood vessels, phlebitis, leg ulcers)	☐ Y ☐ N					
c) Cancer, tumor, or lymph node enlargement (indicate type of cancer and location)	☐ Y ☐ N					
d) Acquired Immuno Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)	☐ Y ☐ N					
e) High blood pressure (if yes, provide most recent reading)	☐ Y ☐ N					
f) Diabetes or disorder of endocrine system or glands (indicate if insulin dependent)	☐ Y ☐ N					
g) Alcohol or drug use, abuse, and/or dependency	☐ Y ☐ N					
h) Disease of the kidney, bladder or urinary tract	☐ Y ☐ N					
i) Crohns, colitis, diseases of stomach, intestine, esophagus or gallbladder	☐ Y ☐ N					
j) Disorder of the liver or pancreas	☐ Y ☐ N					
k) Disorder of the lungs or respiratory system	☐ Y ☐ N					
l) Organ transplants (if yes, include type and date)	☐ Y ☐ N					
m) Neurologic problems–disorder of the brain, seizures, epilepsy, central nervous system–stroke or paralysis	☐ Y ☐ N					
n) Nervous, mental, depression, stress or anxiety related disorder, eating disorder	☐ Y ☐ N					
o) Disorder of the blood (including anemia)	☐ Y ☐ N					
p) Lupus or arthritis (if yes, indicate type and severity of disability)	☐ Y ☐ N					
q) Congenital anomalies or disorders	☐ Y ☐ N					
r) **OTHER** (any disease/condition not listed above)	☐ Y ☐ N					