



Oxford Health Plans

Family Health Statement

Mailing Address: P.O. Box 7081, Bridgeport, CT 06601-7081 • 203-852-1442 • 800-444-6222 **Corporate Address:** 800 Connecticut Ave., Norwalk, CT 06854

NEW EMPLOYEE ADD EXISTING EMPLOYEE CHANGE

To Be Completed By Employer (Please print in ink all information requested on this application.)

NAME OF EMPLOYER		EMPLOYER STREET ADDRESS		CITY	STATE	ZIP
POLICY NUMBER	APPLICANTS OCCUPATION		EMPLOYEE SALARY	HOURS WORKED/WEEK	DATE OF FULL-TIME HIRE	

To Be Completed By Employee (Complete for all family members applying for coverage.)

LAST NAME	FIRST NAME & MI	HEIGHT	WEIGHT	BIRTHDATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	FULL TIME STUDENT. IF YES, LIST SCHOOL. <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME	FIRST NAME & MI	HEIGHT	WEIGHT	BIRTHDATE	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	FULL TIME STUDENT. IF YES, LIST SCHOOL. <input type="checkbox"/> YES <input type="checkbox"/> NO
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EMPLOYEE STREET ADDRESS		CITY	STATE	ZIP	EMPLOYEE SOCIAL SECURITY NO	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED
HOME PHONE	BUSINESS PHONE	BEST PLACE TO CALL DURING DAY <input type="checkbox"/> HOME <input type="checkbox"/> WORK		EMPLOYEE BIRTH PLACE	SPOUSE BIRTH PLACE	
DOES YOUR SPOUSE HAVE GROUP COVERAGE ELSEWHERE? <input type="checkbox"/> YES <input type="checkbox"/> NO		DOES ANY PROPOSED INSURED HAVE OTHER HEALTH/LIFE COVERAGE? AMOUNT \$ _____		HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED, RATED OR DECLINED? (SUBMIT DETAILS)		
I WISH TO ENROLL FOR:				IS ANY PERSON TO BE INSURED ELIGIBLE FOR MEDICARE? IF SO, PLEASE BE SPECIFIC. <input type="checkbox"/> YES <input type="checkbox"/> NO		
HEALTH	EMPLOYEE <input type="checkbox"/>	SPOUSE <input type="checkbox"/>	DEPENDENT <input type="checkbox"/>	MEDICARE A _____ MEDICARE B _____		
DENTAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
LIFE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
AMOUNT OF LIFE INSURANCE REQUESTED				IS ANY PROPOSED INSURED CURRENTLY COVERED UNDER COBRA?		
NAME OF BENEFICIARY						
CURRENT LIFE AMOUNT				I DECLINE TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT CHILD(REN)		
DISABILITY <input type="checkbox"/>						

I hereby request group insurance for myself and, if the plan provides dependent insurance, for my dependents indicated above and hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if applicable, to apply toward the premiums for the insurance provided for in the policy of group insurance issued to my employer. I understand that if I and/or my dependents decline coverage and desire to participate in the plan at a later date, evidence of insurability satisfactory to the insurance company must be furnished.

X

SIGNATURE OF EMPLOYEE

DATE

	YES	NO
1. Are you now actively at work on a full-time basis?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you or any dependent been hospitalized, advised to be hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you or any dependents to be covered currently pregnant? If yes, please give expected delivery date: _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which this is used. _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you or any dependents had medical expenses in excess of \$5,000 in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>

Have you or any dependent ever had or been told they had, been medically counseled, consulted or treated for any of the following: (Check "yes" or "no" and circle applicable disorder. Please provide details in the table below.)

<p>YES NO</p> <p>A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis or gout? <input type="checkbox"/> <input type="checkbox"/></p> <p>B. High blood pressure? If yes, provide most recent reading. _____ <input type="checkbox"/> <input type="checkbox"/></p> <p>C. Cancer, tumor or lymph node enlargement? (indicate type of cancer and location) <input type="checkbox"/> <input type="checkbox"/></p> <p>D. Sexually transmitted disease? <input type="checkbox"/> <input type="checkbox"/></p> <p>E. Mental, emotional, nervous disorder, stress related disorder, depression, anxiety, psychotherapy or counseling of any kind? <input type="checkbox"/> <input type="checkbox"/></p> <p>F. Brain disorder, neurologic problems, seizure disorder or epilepsy, any disorder of the central nervous system, stroke or paralysis? <input type="checkbox"/> <input type="checkbox"/></p> <p>G. Alcohol or drug use, abuse/and/or dependency? <input type="checkbox"/> <input type="checkbox"/></p> <p>H. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? <input type="checkbox"/> <input type="checkbox"/></p> <p>I. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? <input type="checkbox"/> <input type="checkbox"/></p> <p>J. Back, neck, bone, joint problems? <input type="checkbox"/> <input type="checkbox"/></p> <p>K. Lupus or arthritis? If so, please indicate type and severity of disability. <input type="checkbox"/> <input type="checkbox"/></p> <p>L. Tuberculosis? <input type="checkbox"/> <input type="checkbox"/></p> <p>M. Anemia or other disorder of the blood? <input type="checkbox"/> <input type="checkbox"/></p>	<p>YES NO</p> <p>N. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medication (if any). <input type="checkbox"/> <input type="checkbox"/></p> <p>O. Any disorder of the stomach, intestines, gallbladder or esophagus? <input type="checkbox"/> <input type="checkbox"/></p> <p>P. Any disorder of the lungs or respiratory system? <input type="checkbox"/> <input type="checkbox"/></p> <p>Q. Any disorder of the kidneys, bladder or urinary tract? <input type="checkbox"/> <input type="checkbox"/></p> <p>R. Any disorder of the liver or pancreas? <input type="checkbox"/> <input type="checkbox"/></p> <p>S. Any disorder of the endocrine system or glands? <input type="checkbox"/> <input type="checkbox"/></p> <p>T. Within the last two years, have you or any dependents ever had, been told they had, consulted or treated for any of the following:</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">YES NO</td> <td style="width: 50%;">YES NO</td> </tr> <tr> <td>1. Asthma <input type="checkbox"/> <input type="checkbox"/></td> <td>7. Lyme Disease <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>2. Bronchitis <input type="checkbox"/> <input type="checkbox"/></td> <td>8. Nose/Throat Problems <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>3. Chiropractic Care <input type="checkbox"/> <input type="checkbox"/></td> <td>9. Sinusitis <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>4. Ear Problems <input type="checkbox"/> <input type="checkbox"/></td> <td>10. Skin Problems <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>5. Eye Problems <input type="checkbox"/> <input type="checkbox"/></td> <td>11. Thyroid/Goiter Problems <input type="checkbox"/> <input type="checkbox"/></td> </tr> <tr> <td>6. Headaches/Migraines <input type="checkbox"/> <input type="checkbox"/></td> <td>12. Urinary Tract Infections <input type="checkbox"/> <input type="checkbox"/></td> </tr> </table> <p>U. Are you or any dependents planning any dental treatments? <input type="checkbox"/> <input type="checkbox"/></p> <p>V. Have you or any dependents had an examination or treatment for any other illness or injury other than those stated above? <input type="checkbox"/> <input type="checkbox"/></p>	YES NO	YES NO	1. Asthma <input type="checkbox"/> <input type="checkbox"/>	7. Lyme Disease <input type="checkbox"/> <input type="checkbox"/>	2. Bronchitis <input type="checkbox"/> <input type="checkbox"/>	8. Nose/Throat Problems <input type="checkbox"/> <input type="checkbox"/>	3. Chiropractic Care <input type="checkbox"/> <input type="checkbox"/>	9. Sinusitis <input type="checkbox"/> <input type="checkbox"/>	4. Ear Problems <input type="checkbox"/> <input type="checkbox"/>	10. Skin Problems <input type="checkbox"/> <input type="checkbox"/>	5. Eye Problems <input type="checkbox"/> <input type="checkbox"/>	11. Thyroid/Goiter Problems <input type="checkbox"/> <input type="checkbox"/>	6. Headaches/Migraines <input type="checkbox"/> <input type="checkbox"/>	12. Urinary Tract Infections <input type="checkbox"/> <input type="checkbox"/>
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DETAILS REGARDING ANY OF THE ABOVE STATED CONDITIONS (IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE PIECE OF PAPER)
 ADDITIONAL PAPER ATTACHED YES NO

QUESTION NUMBER	NAME	ILLNESS OR NATURE OF COMPLAINT/TREATMENT OR MEDICATION	DURATION DATES		DEGREE OF RECOVERY*	NAME AND ADDRESS OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER
			FROM MO/YR	TO: MO/YR		

**If not completely recovered, please indicate whether you are still receiving care.*

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.

Authorization to Obtain and Disclose Information in Connection with Eligibility for Group Insurance

TO: All providers of medical or dental services or supplies and their representative, the Medical Information Bureau, Inc. or other organizations, all insurers, medical or hospital service plans, prepaid health plans, employers, group policyholders or contractholders.

For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish any information available about the medical history, condition and treatment of the Employee, or any Dependents listed in this Health Statement, including but not limited to information related to psychiatric, alcohol and drug abuse, and HIV conditions.

I authorize the use of such information and the redisclosure of this information for the above purposes to its representatives, other organizations, and their representatives, any insurer, medical or hospital service plan, prepaid health plan or reinsurer. I also authorize the user to redisclose such information to any attending physician for treatment purposes and when necessary to inform the employee of the reason insurance was declined, to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, to any person who has an authorization specifically permitting the redisclosure and as may be permitted or required by law.

In order to assist my employer in selecting a health insurance plan, I acknowledge that this information may be presented to more than one insurer.

I agree that this authorization is valid for 30 months from the date below and a copy shall be as valid as the original. I know that I have a right to ask for and receive a copy of this authorization.

X _____
 SIGNATURE OF EMPLOYEE

X _____
 SIGNATURE OF SPOUSE

 DATE