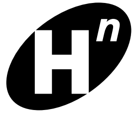

Health Net®

Medical Evaluation Form

For groups with 2-9 enrolled employees

Employer Name: ______________________ Employee Social Security Number: ______________________

Employee Name: ______________________ (Last First MI) Date of Birth ________ Height ________ Weight ________

Spouse Name: ______________________ (Last First MI) Date of Birth ________ Height ________ Weight ________

Child Name: ______________________ (Last First MI) Date of Birth ________ Height ________ Weight ________

Child Name: ______________________ (Last First MI) Date of Birth ________ Height ________ Weight ________

Child Name: ______________________ (Last First MI) Date of Birth ________ Height ________ Weight ________

Do you, your spouse, or any dependent children reside outside of Arizona? ❑ Yes ❑ No

If yes, give details, name and state: ______________________

Have you or any member of your family **who is applying for coverage,** been diagnosed, received treatment or are currently receiving treatment for any of the following conditions within the past 5 years (please complete each question and provide details in the explanation section of this form):

- ❑ Yes ❑ No **1.** Cancer or tumor?
- ❑ Yes ❑ No **2.** Diabetes?
- ❑ Yes ❑ No **3.** Alcohol/illicit drug use or abuse?
- ❑ Yes ❑ No **4.** Liver disease/Cirrhosis/Hepatitis?
- ❑ Yes ❑ No **5.** Lung or respiratory conditions?
- ❑ Yes ❑ No **6.** Gall bladder, liver, stomach or intestines?
- ❑ Yes ❑ No **7.** Immune system (AIDS, ARC)?
- ❑ Yes ❑ No **8.** Psychological conditions?
- ❑ Yes ❑ No **9.** Heart conditions/hypertension/stroke?
- ❑ Yes ❑ No **10.** Bones/joints/muscles/arthritis?
- ❑ Yes ❑ No **11.** Kidney/urinary tract/bladder (stones, infection)?
- ❑ Yes ❑ No **12.** Neurological conditions (headache, seizures)?
- ❑ Yes ❑ No **13.** Eye, ear, nose and throat condition?
- ❑ Yes ❑ No **14.** Reproductive disorders or STD (Sexually Transmitted Disease)
- ❑ Yes ❑ No **15.** Are there any ongoing disabilities?
- ❑ Yes ❑ No **16.** Are you or your spouse/dependent currently pregnant?
- ❑ Yes ❑ No **17.** Are you, or your spouse/dependent taking or have taken any medications in the last 12 months?
- ❑ Yes ❑ No **18.** Have you, your spouse, or any dependent children been a patient in a hospital, clinic, surgi-center, sanatorium, urgent care facility, or other medical facility as an inpatient or outpatient?
- ❑ Yes ❑ No **19.** Have any claims over $5,000 been billed in the last 18 months?
- ❑ Yes ❑ No **20.** Other?

EXPLANATION SECTION

Explain any "Yes" below (attach additional sheet if necessary)

Question #	Name/Age	Date of Diagnosis	Diagnosis, Date Diagnosed and/or Medications (Name of medication, dosage, frequency, reason for taking/diagnosis)	Date Last Treated	Doctor's Name/Phone

I represent that, to the best of my knowledge, the information provided on this Medical Evaluation Form is complete and accurate. I understand that if I have misstated or omitted any information on this form, Health Net of Arizona, Inc. and/or Health Net Life Insurance Co. may reassess premium applied to my employer group and/or me. I, or my authorized agent, am entitled to receive a copy of this authorization. A photocopy of this authorization is as valid as the original.

Use and Disclosure of Information: I acknowledge that health care providers may disclose health information about me or my dependents, including information regarding substance abuse or mental/emotional conditions, to Health Net. Health Net will use and disclose this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement, disease or case management programs as permitted by law.

Employee Signature ______________________ **Date Signed** ______________