



Medical Evaluation Form

For groups with 10-25 enrolled employees

Health Net®

Employer Name: _____ Employee Social Security Number: _____

Employee Name: _____ Date of Birth _____ Height _____ Weight _____
Last First MI

Spouse Name: _____ Date of Birth _____ Height _____ Weight _____
Last First MI

Child Name: _____ Date of Birth _____ Height _____ Weight _____
Last First MI

Child Name: _____ Date of Birth _____ Height _____ Weight _____
Last First MI

Child Name: _____ Date of Birth _____ Height _____ Weight _____
Last First MI

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 (please complete each question and provide details in the explanation section of this form):

- Yes No 1. Have you or your dependents visited a health care professional including inpatient or outpatient hospitalization in the past 5 years for any illness, injuries, medical condition or surgery (including mental health, chemical dependency and infertility)?
- Yes No 2. Have you or your dependents been prescribed or taken any prescription medications for more than 30 days in the past 12 months?
- Yes No 3. Are you or your dependents aware of any condition, illness or injury that may require (ongoing or future) surgery or treatment of any type, or has any surgery or treatment been recommended that has not yet been performed?
- Yes No 4. Are you or your dependents currently pregnant?

| 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 |
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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 _____