

# STATEMENT OF HEALTH

**Important: Please print or type all sections in black ink.**

- New Enrollment  Add Dependent Coverage  Transfer from HMO to PPO/SDHP/Indemnity Coverage  
 Late Enrollment (enrolling more than 31 days after becoming eligible)  Other:

### A. Employer Information

Employer	Group Number
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This Statement is For:  Employee  Spouse  Child

### B. Employee and Dependent(s) Information

	Name	Date of Birth	Sex (circle)	Height - feet-inches	Weight	Place of Birth (State)
Employee		/ /	M F			
Spouse		/ /	M F			
Child		/ /	M F			
Child		/ /	M F			

If more dependents are enrolling, attach a separate sheet of paper, sign and date all additional papers.

### C. Medical Information

The medical information completed on this form may not be used to deny coverage to the individuals applying for coverage.

**Instructions:** Answer questions 1 through 9 with respect to the employee and dependent(s). If answer to any question is "YES," give details in space provided below.

	Yes	No
<b>1. Have you or a dependent ever been treated for or ever had any known indications of: (Circle the applicable items)</b>		
1a. Disease or disorder of eyes, ears, nose or throat?		
1b. Dizziness, fainting, convulsions, paralysis or stroke; mental or nervous disease or disorder?		
1c. Shortness of breath; blood spitting; bronchitis or other chronic respiratory disease or disorder?		
1d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels? <b>If yes, please complete the Supplementary Medical Information on the reverse side of this form.</b>		
1e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gall bladder?		
1f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of bladder, prostate or reproductive organs?		
1g. Disorder of the kidney or kidney disease? <b>If yes, please complete the Supplementary Medical Information on the reverse side of this form.</b>		
1h. Cancer, cyst or tumor? Ever undergone chemotherapy or radiation treatment? <b>If yes, please complete the Supplementary Medical Information on the reverse side of this form.</b>		
1i. Diabetes; thyroid or glandular disorder; skin disease or disorder? <b>If yes, please complete the Supplementary Medical Information on the reverse side of this form.</b>		
1j. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back or joints?		
1k. Deformity, congenital anomaly, or amputation?		

	Yes	No
1l. Allergies; anemia, other blood or lymph disease or disorder?		
1m. Disorder of menstruation, infertility, pregnancy, multiple or premature births, female organs or breasts?		
<b>2. Have you or a dependent ever been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or any other immune system deficiency (except HIV)?</b>		
<b>3. Are you or a dependent now under observation or treatment by a physician or practitioner?</b>		
<b>4. Have you or a dependent ever been evaluated or considered for any type of transplant? If yes, please complete the Supplementary Medical Information on the reverse side of this form.</b>		
<b>5. Other than as stated in answers to questions 1, 2, 3 and 4, have you or a dependent within the past 5 years:</b>		
5a. Been attended by physician/practitioner for consultation, examination, diagnosis or treatment?		
5b. Had any illness, injury or surgery?		
5c. Been a patient in a hospital, clinic, or other medical facility?		
5d. Had electrocardiogram, X-ray, or other diagnostic test?		
5e. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?		
<b>6. Have you or a dependent ever been addicted to alcohol, drugs or any other substance?</b>		
<b>7. Have you or a dependent ever been advised of an elevated cholesterol problem?</b>		
<b>8. Are you or a dependent currently pregnant?</b>		
<b>9. Are you or a dependent currently taking prescription drugs for a condition not mentioned above?</b>		

Question Number	Covered Person: Employee, Spouse or Child	Disease/ Diagnosis	Onset:			Treatment and Result (mention any surgery performed)	Names and Addresses of Physicians/Hospitals
			Mo.	Yr.	Duration		

**Note: If more space is required, provide additional details on a separate piece of paper. Please sign and date all additional papers.**

### D. Authorization

- I agree:** All information on this form is correct and true.
- Authorization to obtain or release medical information:** I authorize any insurance company, health care service plan, health maintenance organization (HMO), physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this form to give PacifiCare or its designated agent any and all records pertaining to any medical history, including drug and/or alcohol abuse treatment or prevention, services or treatment provided to anyone listed on this application for purposes of review, investigation or evaluation as required by law. This authorization becomes effective immediately and shall remain in effect as long as necessary to process claims. A photocopy of this authorization is as valid as the original.

On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

Employee Signature	Date	Signature of Spouse (Required only if spouse is to be covered)	Date
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Original - PacifiCare

SUPPLEMENTARY MEDICAL INFORMATION

Important: Please print or type all sections in ink. If more space is required, use an additional form or separate sheet of paper. Please sign and date all additional pages.

Answer the following only if questions 1d, 1g, 1h, 1i, or 4 on the reverse side of this form were answered with a "YES".

The statement is for: [ ] Employee [ ] Spouse [ ] Child

- 1. Diagnosis or symptoms:
2. Underlying cause:
3. Age and date diagnosed:
4. Date first treated:
5. Are you currently taking any medication?
6. What type of treatment was performed?
7. Is there any history of hospitalization or emergency room treatment?
8. Are there any complications or residual problems?
9. List your last blood pressure reading and the date it was recorded.
10. List all physicians seen within the last 2 years including dates and reason for consultation.

Diabetic Applicants: If question 1i on the reverse was answered with a "YES," answer the following questions in addition to 1-10 above.

- 11. Is there any history of high blood sugar or low blood sugar problems?
12. Is there any history of eye, kidney, cardiovascular, circulatory or skin disorders?

Cardiac/Circulatory/Elevated Blood Pressure Applicants: If question 1d on the reverse was answered with a "YES," answer the following questions in addition to 1-10 above.

- 13. Do you have a history of chest pain?
14. Have you ever had a heart attack?

Employee Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Spouse \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_
(Required only if Spouse is to be covered)