

**Health Statement
(Groups of 2-9)
Health Core Services**

Employee's Name	Control Number	Employee's Social Security Number
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1. **Only the names of Individuals(s) Requesting Coverage at this Time Should be Listed.** Check here if additional dependent children are listed on a separate attachment. (Be sure to include their sex, birthdate, height and weight.)

Name	Sex	Birthdate	Height	Weight
Employee:				
Spouse:				
Dependent Children:				

2. Statement of Health for Individual (s) Listed Above. Give complete dates and details for all "Yes" answers and/or medical impairments checked using the space provided after Question 16.

Yes	No	1. Is diagnostic testing or an operation recommended or contemplated for anyone?																					
___	___	2. Is anyone pregnant?																					
___	___	3. Is anyone taking any medication or receiving any treatment? If "Yes", list individual(s), all medications and dosages, and indicate the underlying condition and/or type of treatment being received.																					
Within the past 3 YEARS, have any individuals:																							
___	___	4. Had accident, health or life insurance modified, postponed, rated or declined? If "Yes", give complete details.																					
___	___	5. Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels (circulatory system)?																					
___	___	6. Been treated for mental, emotional, or nervous disorder or depression?																					
___	___	7. Been treated for cancer, tumor or other malignancy?																					
___	___	8. Been treated for stroke, TIA (mini-stroke) or paralysis?																					
___	___	9. Been treated for emphysema, other respiratory or lung diseases or breathing conditions?																					
___	___	10. Been treated for diseases of the kidney, pancreas or liver?																					
___	___	11. Been treated for or diagnosed as having immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus ("HIV") or other immune system disorders?																					
___	___	12. Been diagnosed with diabetes? If "Yes", give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.																					
___	___	13. Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.																					
___	___	14. Been confined in a hospital, clinic, sanitarium or other medical facility?																					
___	___	15. Had any disease or impairment or treatment for any of the following? If "Yes", check the appropriate box(es) below and explain using the space provided.																					
<table style="width:100%; border:none;"> <tr> <td>___ Alcohol Abuse</td> <td>___ Bone/Joint</td> <td>___ Epilepsy</td> <td>___ Infertility</td> <td>___ Lupus</td> <td>___ Skin</td> <td>___ Other</td> </tr> <tr> <td>___ Back/Neck</td> <td>___ Brain</td> <td>___ Ears/Eyes</td> <td>___ Intestines</td> <td>___ Migraines</td> <td>___ Stomach</td> <td>_____</td> </tr> <tr> <td>___ Blood</td> <td>___ Drug Abuse</td> <td>___ Heart</td> <td>___ Lungs</td> <td>___ Neurological</td> <td>___ Venereal Disease</td> <td>_____</td> </tr> </table>			___ Alcohol Abuse	___ Bone/Joint	___ Epilepsy	___ Infertility	___ Lupus	___ Skin	___ Other	___ Back/Neck	___ Brain	___ Ears/Eyes	___ Intestines	___ Migraines	___ Stomach	_____	___ Blood	___ Drug Abuse	___ Heart	___ Lungs	___ Neurological	___ Venereal Disease	_____
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___	___	16. Does anyone have any known physical impairment or ill health not mentioned above? If "Yes", give complete details below.																					

USE this space to provide complete dates and details for all "Yes" answers and/or medical impairments checked above.

Indicate the number of the question and provide the **Name of the Individual, Nature of the disorder/Injury, Dates and Type of Treatment, and Current Condition.** Please include additional information as requested in Questions 3,4,12,13,15 and 16.

___ Indicate here if additional information is on a separate attachment.

Certification: I certify that these answers and statements are complete and true to the best of my knowledge and belief. I agree that this document shall form a part of my request for insurance and I acknowledge that I have been given a copy of this document as completed by me. I understand that the information provided will not effect my eligibility to participate in this plan.

Employee's Signature _____

Date Signed _____

Spouse's Signature (Required if spouse coverage is being requested) _____