Individual Health Statement

Employee's Name	Control Number	Employee's Social Security Number

1. **Only the Names of Individual(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, birth date, height and weight.)

Name	Sex	Birth date (MM/DD/YYYY)	Height (ft., in.)	Weight (lbs.)
Employee:	☐ M ☐ F			
Spouse:	☐ M ☐ F			
Dependent Children:	☐ M ☐ F			
	☐ M ☐ F			
	☐ M ☐ F			

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 15.

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 of being received.
		Within the past 3 YEARS, has any individual(s):
☐	☐	4. Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels (circulatory system)?
☐	☐	5. Been treated for mental, emotional or nervous disorder or depression?
☐	☐	6. Been treated for cancer, tumor, or other malignancy?
☐	☐	7. Been treated for stroke, TIA (mini-stroke) or paralysis?
☐	☐	8. Been treated for emphysema, other respiratory or lung diseases or breathing conditions?
☐	☐	9. Been treated for diseases of the kidney, pancreas or liver?
☐	☐	10. Been treated for or diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS") or Human Immunodeficiency Virus ("HIV") or other immune system disorders?
☐	☐	11. Been treated with diabetes? If "Yes", give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.
☐	☐	12. Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.
☐	☐	13. Been confined in a hospital, clinic, sanitarium or other medical facility?
☐	☐	14. Had any disease or impairment of or treatment for any of the following: If "Yes", check the appropriate box(es) below and explain using the space provided.

☐ 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	

Yes	No	
☐	☐	15. Does anyone have any known physical impairment or ill health not mentioned above? If "Yes", give 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 Disorder/Injury, Dates and Type of Treatment, and Current Condition.** Please include additional information as requested in Questions 3, 11, 12, 14 and 15.

☐ *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______________ at ______________________________
City State

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