



# Individual Health Statement

Employee's Name	Control Number	Employee's Social Security Number
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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:	<input type="checkbox"/> M <input type="checkbox"/> F			
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Children:	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> 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	
<input type="checkbox"/>	<input type="checkbox"/>	1. Is diagnostic testing or an operation recommended or contemplated for anyone?
<input type="checkbox"/>	<input type="checkbox"/>	2. Is anyone pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	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.
<b>Within the past 3 YEARS, has any individual(s):</b>		
<input type="checkbox"/>	<input type="checkbox"/>	4. Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels (circulatory system)?
<input type="checkbox"/>	<input type="checkbox"/>	5. Been treated for mental, emotional or nervous disorder or depression?
<input type="checkbox"/>	<input type="checkbox"/>	6. Been treated for cancer, tumor, or other malignancy?
<input type="checkbox"/>	<input type="checkbox"/>	7. Been treated for stroke, TIA (mini-stroke) or paralysis?
<input type="checkbox"/>	<input type="checkbox"/>	8. Been treated for emphysema, other respiratory or lung diseases or breathing conditions?
<input type="checkbox"/>	<input type="checkbox"/>	9. Been treated for diseases of the kidney, pancreas or liver?
<input type="checkbox"/>	<input type="checkbox"/>	10. Been treated for or diagnosed as having Acquired Immune Deficiency Syndrome ("AIDS") or Human Immunodeficiency Virus ("HIV") or other immune system disorders?
<input type="checkbox"/>	<input type="checkbox"/>	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.
<input type="checkbox"/>	<input type="checkbox"/>	12. Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.
<input type="checkbox"/>	<input type="checkbox"/>	13. Been confined in a hospital, clinic, sanitarium or other medical facility?
<input type="checkbox"/>	<input type="checkbox"/>	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.
		<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Bone/Joint <input type="checkbox"/> Epilepsy <input type="checkbox"/> Infertility <input type="checkbox"/> Lupus <input type="checkbox"/> Skin <input type="checkbox"/> Other
		<input type="checkbox"/> Back/Neck <input type="checkbox"/> Brain <input type="checkbox"/> Ears/Eyes <input type="checkbox"/> Intestines <input type="checkbox"/> Migraines <input type="checkbox"/> Stomach
		<input type="checkbox"/> Blood <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Neurological <input type="checkbox"/> Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	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) \_\_\_\_\_