HEALTH STATEMENT

For Groups with less than 14 Eligible Employees

EMPLOYEE NAME	LAST	FIRST	MI
EMPLOYER NAME			

Answer the following questions about yourself or any family member applying for coverage. **Give details** for any **YES** responses in the section below.

1. During the past 12 months has medical expenses in excess of $10,000 been incurred? ……………………………..……………..… YES NO
2. Is anyone currently pregnant? YES NO Expected delivery date? ____________________ C-section planned? ….….. YES NO
3. Does anyone have any chronic medical conditions, such as diabetes, hypertension, cancer, heart condition, lung disease, kidney disorder or AIDS/ARC? ……………………………………………………………………………………………………….…… YES NO
4. Has anyone had surgery or been hospitalized in the last 5 years? ………………………………………………………….……………. YES NO
5. Is surgery or hospitalization anticipated within the next 6 months? ……………………………………………………………. YES NO
6. Is anyone currently disabled or has been disabled in the last 2 years? ……………………………………………………..…. YES NO
7. Is anyone currently taking medications? ……………………………………………………………………….…………….. YES NO

1. Height _________ EMPLOYEE	Weight _________	Height________ SPOUSE	Weight________

Question # _______

Name of person treated: ____________________
Diagnosis/condition: ____________________
Type of treatment: ____________________
Type of treatment: ____________________ Date treatment ended: ____________________
Testing (laboratory/radiology, findings): ____________________
Medication/dosage: ____________________
Hospitalization (reason/dates: ____________________
Degree of recover (any residuals, continued treatment?) ____________________
____
Name and address of physician or practitioner: ____________________

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____
Name and address of physician or practitioner: ____________________

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACHED A SEPARATE STATEMENT. BE SURE TO SIGN AND DATE YOUR ATTACHMENT.

I certify that these answers and statements, including those on any attachments, are complete and true to the best of my knowledge and belief. I understand that this document shall form a part of my request for health coverage. I understand that any fraudulent or other material misstatements or omissions I make on this form may result in cancellation or termination of coverage for my dependents and me.

I authorize any "provider of health care" to disclose to Western Health Advantage or their designated agents, all "medical information" (as these terms are defined in the Civil Code), including all mental/emotional disorders, pertaining to me. This information is collected for the purpose of evaluating my application. This authorization will remain valid for 30 days from the date below. A photocopy of this authorization is as valid as the original. My authorized agent or myself is entitled to receive a copy of this authorization.

____ ____
SIGNATURE OF EMPLOYEE Date SIGNATURE OF SPOUSE (If applying) Date