CALIFORNIA

UnitedHealthcare®
PacifiCare®

Small Business Individual Health Statement Application

Unimerica Insurance Company

▪ Type or Print in Black Ink ▪ Please submit in a sealed envelope along with your completed Employee Enrollment Form

Employer Name

Section A. Employee Information (Complete for all enrolling family members)

	First Name	Middle	Last	SS#	Date of Birth Mo/Day/Yr	Height	Weight	Sex
Employee								
Spouse								
Child								
Child								
Child								
Child								

Section B. For any "yes" answers, please give details in Section D

1. a. Is any female to be insured/covered currently pregnant? ☐ Yes ☐ No
   b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application? ☐ Yes ☐ No
   c. If yes to "a" or "b", is there current or a history of complications or multiple gestation birth? ☐ Yes ☐ No
   d. If yes, to "a" or "b", indicate the due date (month/year) _____ /_____
2. In the last five years, have you or any eligible dependents incurred medical expenses in excess of $5,000.00? ☐ Yes ☐ No
3. Within the past five years, has any person to be insured/covered been diagnosed or treated by a physician or member of the medical profession or hospitalized for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
4. Has any person to be insured/covered: during the last 24 months had surgery or been confined in any hospital, convalescent facility, skilled nursing facility, rehabilitation facility or mental health facility ☐ Yes ☐ No
5. Within the past five years, has any person to be insured/covered been diagnosed or been treated by a physician or member of the medical profession or hospitalized for any of the following conditions: Cancer or Tumor, Diabetes, Heart or Vascular Disorder, Kidney Disorder, Liver Disorder, Intestines or Stomach Disorder, Musculoskeletal Conditions, Neurological Disease, Respiratory or Lung Disorder, Stroke, Systemic Lupus or Multiple Sclerosis, Organ Transplants, or Mental or Behavioral Health Disorder? ☐ Yes ☐ No
6. Within the past five years, has any person to be insured/covered been diagnosed or treated by a physician or member of the medical profession for anemia, blood clots, hemophilia, hyperlipidemia, polycythemia, thrombocytopenia, Von Willebrand's Disease, or any blood vessel disorder? ☐ Yes ☐ No
7. Within the last 12 months, has any person to be insured/covered taken medicine prescribed by a physician or member of the medical profession? (If yes, list medication names in Section D.) ☐ Yes ☐ No

Section C. For groups enrolling 2 10 employees or late enrollees, complete the following medical history section below.

To the best of your knowledge, within the past five years, has any person to be insured/covered ever been diagnosed or treated for any of the following conditions by a medical professional?

A. Alcohol/Drug Abuse ☐ Yes ☐ No
B. Arthritis/Back/Joint Disorder ☐ Yes ☐ No
C. Asthma/Tobacco Usage ☐ Yes ☐ No
D. Breast Disorder or Breast Implants ☐ Yes ☐ No
E. Congenital Disorder or Deformity ☐ Yes ☐ No
F. Digestive/Eating Disorder ☐ Yes ☐ No
G. Ear/Eye Disorder ☐ Yes ☐ No
H. Epilepsy/Seizures ☐ Yes ☐ No
I. Genital/Urinary Disorder ☐ Yes ☐ No
J. High Blood Pressure ☐ Yes ☐ No
K. Infertility ☐ Yes ☐ No
L. Muscle Disorder/Neurological Disease ☐ Yes ☐ No
M. Skin Disease ☐ Yes ☐ No
N. Thyroid/Adrenal Disorder ☐ Yes ☐ No
O. Tuberculosis/Hepatitis A, B or C ☐ Yes ☐ No
P. Sleep Apnea ☐ Yes ☐ No
Q. Systemic Infection ☐ Yes ☐ No

Section D. Detailed answers to Sections B. and C.

Provide full details to all "Yes" answers in Section B and C. Attach a separate page if necessary.

Eligible Person	Nature of Illness/Injury	Mo/Yr	Medication/ Treatment	Recovered (Yes or No)	Explanation/Comments
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

Section E. Authorization

To the best of my knowledge and belief, all information on this form is correct and true. I further authorize my employer to deduct from my earnings any contribution required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week (or 20–29 hours per week if elected by my employer).

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

Employee Printed Name	
Employee Signature	Date

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.