State of New Hampshire

Family Health Statement

For Internal Use Only		
Employer/Group Name	Group Number	Effective Date / /

Please print clearly and complete this form in black ink. Please provide all requested information for each person eligible to be covered.

Employee Name: (First) **(M.I.)** **(Last)**

Marital Status
❑ Single
❑ Married

Home Address: **City** **State** **Zip**

Indicate the type of coverage you are applying for:
❑ Employee Only ❑ Employee-One Child ❑ Employee-Family (spouse & children)
❑ Employee-Spouse ❑ Employee-Children

Part 1 - EMPLOYEE/DEPENDENT INFORMATION – List yourself and all eligible dependents to be covered.

Relation	Sex	Last Name	First name	M.I.	Social Security Number	Height	Weight	Disabled	Full-time Student	Date of Birth
employee	M F							Y N		___/___/___
	M F							Y N	Y N	___/___/___
	M F							Y N	Y N	___/___/___
	M F							Y N	Y N	___/___/___
	M F							Y N	Y N	___/___/___

Part 2 - WAIVER / REFUSAL OF COVERAGE – You MUST complete this section if any person is waiving (declining) this health insurance.

I have been given the opportunity to apply for group health coverage available to me and my dependents through the above named employer.

I hereby waive group coverage for:

❑ Myself ❑ My Spouse ❑ My Dependent Children

I waive group coverage because:

❑ Spousal coverage ❑ Medicare Supplement ❑ Individual Health Coverage

❑ Coverage under another carrier's plan provided by the above named

I have declined coverage of my own free will without inducement or pressure by my employer, the producer or health insurer. I understand if I and/or my spouse and/or my dependent children waive coverage and desire to participate in the plan at a later date, we may be treated as late enrollees and required to wait until the plan's next scheduled open enrollment period to enroll.

Employee Signature _____ Date _____

If you have waived coverage and signed above – Do not complete the rest of this Family Health Statement.

Part 3 - HEALTH INFORMATION – The information collected on this form will be used for premium rating purposes only. You will not be denied coverage based on your health status. Please provide all requested information for each person to be covered.

1. Has any person to be covered by this plan ever had indications of, been diagnosed with, treated for, or had treatment recommended for any of the following conditions? ❑ No ❑ Yes

If Yes, then place a check beside the condition and provide details in the Medical Details Section in Part 4.

A. ❑ Benign tumor
B. ❑ Blood or circulatory problems
C. ❑ Cancer
D. ❑ Connective Tissue Disease (Marfans or variant)
E. ❑ Heart attack
F. ❑ Heart disease, Angina
G. ❑ Liver condition
H. ❑ Stroke

2. Has any person to be covered by this plan had indications of, been diagnosed with, treated for, or had treatment recommended for any of the following conditions listed in this question and question 3 below within the last 5 years? ❑ No ❑ Yes

If Yes, then place a check beside the condition and provide details in the Medical Details Section in Part 4.

A. ❑ Colitis or intestinal condition
B. ❑ Disease of eyes, ears, nose, or throat
C. ❑ Disorders of spine, discs, joints
Surgery: ❑ Yes ❑ No
Date of surgery _____
D. ❑ Gall bladder disease or gall stones
E. ❑ Kidney disease or kidney stones
F. ❑ Lung condition or tuberculosis
G. ❑ Muscle/nervous system disorder
H. ❑ Paralysis
I. ❑ Reproductive System Disorders/Infertility
J. ❑ Thyroid or goiter
K. ❑ Ulcers, Reflux, Gerd or other stomach conditions

3.

A. ❑ Alcohol or ❑ Drug Abuse/Addiction
❑ Inpatient: Dates treated _____
❑ Outpatient: Dates treated _____

B. ❑ Arthritis or Rheumatism:
Type _____
Medication used within the last 12 months:_____

C. ❑ Asthma or ❑ Other respiratory conditions: _____
Frequency of attacks _____ Date of last attack_____
Dates of any hospitalizations_____
Medication used within the last 12 months_____
How often taken _____

D. ❑ Diabetes:
❑ Diet ❑ Oral medication or ❑ Insulin controlled

E. ❑ Emotional or mental health conditions:
Diagnosis/Condition:_____
❑ Inpatient Dates of admission: _____
❑ Outpatient # of visits within the last 12 months _____
Medication used within the last 12 months _____
Medication was prescribed by: ❑ Psychiatrist ❑ Family Physician
Date medication last used _____

F. ❑ Epilepsy or Seizures:
Type and date of last seizure_____
Medication used within the last 12 months _____

G. ❑ High blood pressure:
Last reading and date _____
Medication used within the last 12 months _____

H. ❑ Lupus: ❑ Systemic ❑ Discoid

Employer Group Name

Part 3 - HEALTH INFORMATION – continued

4. Has any person to be covered by this plan ever been diagnosed with or tested positive for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)? ❑ No ❑ Yes If Yes, then provide details in the Medical Details Section in Part 4.

5. Is any person listed Part 1 of this form currently pregnant or an expectant parent? ❑ No ❑ Yes If Yes, then provide details in the Medical Details Section in Part 4.

6. Has any person to be covered by this plan been advised to have future medical treatment or surgery? ❑ No ❑ Yes If Yes, then provide details in the Medical Details Section in Part 4.

7. Has any person to be covered by this plan used tobacco products in any form within the past 5 years? ❑ No ❑ Yes If Yes, provide user's name(s) _____ and date(s) of last use _____.

8. Has any person to be covered by this plan taken any prescription drugs not already noted within the past 5 years for any illness, injury or condition (excluding colds, flu and routine exams not related to a medical condition)? ❑ No ❑ Yes If Yes, then provide details in the Medical Details Section in Part 4.

9. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional within the past 5 years for any illness, injury or condition not already noted (excluding colds, flu and routine exams not related to a medical condition)? ❑ No ❑ Yes If Yes, then provide details in the Medical Details Section in Part 4.

Part 4 - MEDICAL DETAILS – Please provide complete details for all **YES** answers in Part 3. Attach additional sheets if necessary.

Question Number	Family Member's Name	Condition or Reason	Treatment and/or Medication	Onset Date	Recovery Date	Degree of Recovery	Treating Physician Name, Address and Telephone

Part 5 - FAMILY HEALTH STATEMENT CERTIFICATION

I represent that all statements and answers I have given are complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I will promptly inform the insurance carrier in writing before my coverage takes effect if I become aware that anything has occurred that makes this family health statement incomplete or incorrect. I understand that I or any other adult to be covered by this policy may be contacted for additional information or asked to sign an authorization for the release of medical records. Health care providers listed on this form will not be contacted unless you or your dependent signs a separate written medical authorization.

Employee Printed Name | Employee Signature | Date | Daytime Phone Number