



# Group Health Underwriting Application

Please print clearly.

| Employee Information  |            |            |        |        |                       |                        |
|-----------------------|------------|------------|--------|--------|-----------------------|------------------------|
| Name of Employer      |            |            |        |        | Hours worked per week |                        |
| Employee Last Name    |            | First Name |        | MI     | Gender                | Social Security Number |
| Employee Home Address |            | City       |        | State  | Zip Code              | Date of Birth          |
| Home Phone            | Work Phone |            | Height | Weight | Hire Date             |                        |

| Dependent Information  |                   |                 |               |                     |               |                      |
|--|-------------------|-----------------|---------------|---------------------|---------------|----------------------|
| Applying for coverage:   |                   |                 |               |                     |               |                      |
| Spouse?  |                   | Yes             | No            | Dependent Children? |               | Yes No               |
| Do you have any otherwise eligible family members who are not applying for coverage? |                   |                 |               |                     | Yes           | No                   |
| Reason:  |                   |                 |               |                     |               |                      |
| <i>Dependent Spouse's Last Name</i>  | <i>First Name</i> | <i>Relation</i> | <i>Gender</i> | <i>Height</i>       | <i>Weight</i> | <i>Date of Birth</i> |
|  |                   |                 |               |                     |               |                      |
| <i>Dependent Child's Last Name</i>   | <i>First Name</i> | <i>Relation</i> | <i>Gender</i> | <i>Height</i>       | <i>Weight</i> | <i>Date of Birth</i> |
|  |                   |                 |               |                     |               |                      |
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|  |                   |                 |               |                     |               |                      |

| Waiver and Other Coverage Information   |              |                   |
|---|--------------|-------------------|
| <p>To be completed by employees who are eligible for coverage, but are declining to enroll.</p> <p style="text-align: center;">I have been given the opportunity to participate in the Group Medical Plan provided by my employer. I currently have other group coverage and I am electing to waive participation in this plan for myself and my dependents, if any.</p> <p><b>Please list current coverage below and complete questions 1-5 of the Health Statement on page 2.</b></p> |              |                   |
| Name of Group Medical Plan  | Phone Number | Group or Policy # |
| Names of those covered under this Group Medical Plan  |              |                   |

## Health Statement

|  |     |    |
|--|-----|----|
| 1. Are you or any of your dependents currently receiving medical treatment?<br>Details:  | Yes | No |
| 2. Are you, your spouse or any of your dependents currently pregnant or have reason to believe they may be pregnant or is anyone expecting a baby that would be eligible to be added to the medical plan?<br><br>Name: _____ Estimated Due Date: _____ | Yes | No |
| 3. Have you or any of your dependents ever been denied for health or life insurance, or been issued a modified policy?<br>Details:   | Yes | No |
| 4. Have you or any of your dependents been advised to have a test, surgery or medical treatment that has not been done?<br>Recommended Treatment: _____ Reason declined: _____   | Yes | No |
| 5. Have you or any of your dependents been prescribed or taken any medications, drugs or shots in the past 12 months?<br>Name                      Name of drug(s)                      Purpose for taking                      Last used              | Yes | No |
| <b>If you are waiving coverage, you may stop here and proceed to the signature portion of the application on page 3.</b>   |     |    |
| 6. Have you or your spouse applied for adoption or considered applying for adoption?<br>Date applied: _____ Application Status: _____  | Yes | No |
| 7. Have you or any of your dependents smoked or chewed tobacco?<br>When quit, if applicable?   | Yes | No |
| 8. Have you or any of your dependents been treated, or counseled for, alcohol or illegal drug abuse or dependency?<br>Name: _____ When treated: _____ Abused substance: _____  | Yes | No |
| 9. Have you or any of your dependents had any indications of, diagnosis of, or treatment for any of the following?<br>Please list the <b>corresponding letter, diagnosis date, and treatment details</b> in the space below for any answered "Yes."    |     |    |
| a. Cancer or tumor(s)  | Yes | No |
| b. Diabetes?   | Yes | No |
| c. Blood disorders, including HIV or AIDS?   | Yes | No |
| d. Heart condition, murmur, heart attack, irregular heartbeat, clot, stroke or any circulatory problem?  | Yes | No |
| e. Kidney, liver or pancreatic disease or disorder?  | Yes | No |
|  |     |    |
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|  |  |     |    |
|--|--|-----|----|
| <p>10. Has anyone in the past FIVE (5) years been diagnosed or treated for any of the following?<br/>Please list the <b>corresponding letter</b> and <b>diagnosis date</b> and <b>treatment details</b> in the space below for any answered "Yes."</p> |  |     |    |
| a. Disease or disorder of the eyes, ears, nose or throat?  |  | Yes | No |
| b. Dizziness, fainting, convulsions, paralysis or stroke?  |  | Yes | No |
| c. Mental or nervous disease or disorder?  |  | Yes | No |
| d. Ulcer, hernia, colitis, internal bleeding, jaundice, or other disease or disorder of the stomach, liver or gall bladder?  |  | Yes | No |
| e. Sugar, protein or blood in urine, stone or other disease or disorder of kidney, bladder or prostate?  |  | Yes | No |
| f. Female organs disorder, pregnancy complications, breast lump(s) or breast augmentation?   |  | Yes | No |
| g. Neuritis, arthritis, multiple sclerosis, muscular dystrophy, cerebral palsy, or disease or disorder of the muscles or bones, including back or joints?  |  | Yes | No |
| h. Shortness of breath, bronchitis, asthma, or other respiratory disease or disorder?  |  | Yes | No |
| i. Chest pain, palpitations, high blood pressure or any other cardiovascular disease?  |  | Yes | No |
| j. Thyroid or glandular disorder?  |  | Yes | No |
| k. Skin disease or disorder?   |  | Yes | No |
| l. Deformity, amputation or birth defect?  |  | Yes | No |
| m. Any surgery or hospitalization?   |  | Yes | No |
| <input type="checkbox"/>   |  |     |    |
| <input type="checkbox"/>   |  |     |    |
| <input type="checkbox"/>   |  |     |    |
| <input type="checkbox"/>   |  |     |    |
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| <input type="checkbox"/>   |  |     |    |

|   |     |    |
|---|-----|----|
| <p>11. Do you or any of your dependents have any symptoms or medical problems not explained by any other question?<br/>Details:</p> | Yes | No |
|---|-----|----|

|   |  |
|---|--|
| <p><b>Employee Signature and Certification of Authenticity</b></p> <p>I certify that the information on this form, including the Health Statement on page 2, is complete and accurate. I understand that my health coverage, as well as the health care coverage for the other members of my group, may be cancelled retroactively if this information is found to be inaccurate or incomplete.</p> |  |
| <p>X _____<br/><i>Employee Signature</i></p>  | <p>_____<br/><i>Date Signed</i></p>    |
| <p>I certify that I have updated the information on this application and I hereby reconfirm the accuracy of the information I have provided.</p>  |  |
| <p>_____<br/><i>Employee Initials</i></p>   | <p>_____<br/><i>Date Initialed</i></p> |