Virginia Small Employer Group Health Insurance Medical History Form

Section 1: To Be Completed by Employer

EMPLOYER GROUP NAME	REQUESTED EFFECTIVE DATE / /

Section 2: Employee Information

Employee Name: _____ SSN: _____
Employee Address: (street, city, state & zip) _____
Name of Current Insurer/HMO: _____
Spouse Name: _____ SSN: _____
Spouse Address: (street, city, state & zip) _____
Name of Current Insurer/HMO: _____

INDICATE THE TYPE OF COVERAGE FOR WHICH YOU ARE APPLYING: ❑ Employee Only ❑ Employee and Spouse ❑ Employee and One Child ❑ Employee and Children ❑ Employee and Family

Section 3: Waiver of Coverage

Only complete this section if you wish to decline coverage for yourself, your spouse, other adult and/or your dependents.

I WISH TO DECLINE COVERAGE FOR:
❑ Myself ❑ My Spouse ❑ Other Adult ❑ My Dependents ❑ Myself and All Dependents

I WISH TO DECLINE COVERAGE FOR THE FOLLOWING REASON:

❑ Covered under other group coverage.

Name of Insurer/HMO:_____
Name of Insured: _____

❑ Covered by Medicare ❑ Covered by TRICARE or CHAMPVA
❑ Other (including individual coverage) _____
(provide details)

My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable). I have declined to apply for coverage as indicated above. I understand that by waiving coverage at this time, certain restrictions may apply to my ability to participate in this group insurance program at a later date.

Signature: **Date:** / /

Section 4: Medical History

Please provide the following information about each person to be covered by this policy. If you require more space than is provided, attach additional papers. If child(ren) do not reside at the same address as the employee, please provide the child(ren)'s address.

	First Name & Middle Initial	Last Name (if different from applicant)	Gender M/F	Date of Birth mm/dd/yyyy	Height	Weight	Step Child Y/N	Full-time Student Y/N	Court-Ordered Coverage Y/N
Employee									
Spouse									
Child									

Address if different from employee: (street, city, state & zip)

Employee Name:_____

Section 4: Medical History (con't.)									
	First Name & Middle Initial	Last Name (if different from applicant)	Gender M/F	Date of Birth mm/dd/yyyy	Height	Weight	Step Child Y/N	Full-time Student Y/N	Court-Ordered Coverage Y/N
Child									
Address if different from employee: (street, city, state & zip)									
Child									
Address if different from employee: (street, city, state & zip)									

If you or your spouse are a custodial parent to any dependent listed above, indicate who:

Has anyone named in this application used tobacco products within the past 12 months? ❑ Yes ❑ No
If yes, please explain:

Within the past five (5) years, have you or any other person listed on this form consulted or sought treatment, had treatment recommended, received treatment or therapy, been surgically treated, had surgery recommended, or been hospitalized for any of the following conditions? If yes, check the applicable condition(s) in the column provided.

Yes	Condition
	1. AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)
	2. Alcohol abuse, substance abuse, and/or use of illicit drugs
	3. Allergies
	4. Aneurysm
	5. Arthritis, rheumatism or other condition affecting one or more joints
	6. Asthma or other lung or respiratory disorder disease, emphysema, COPD, cystic fibrosis, sarcodosis
	7. Back disorders, including disorders of the spine and intervertebral discs, and disc herniation/bulge
	8. Blood clots, peripheral vascular disease or other circulatory or vascular disorder
	9. Cancer or any tumor or growth
	10. Diabetes - If yes, what type?
	11. Elevated Cholesterol
	12. Emotional or mental disorders, including, but not limited to, depression, manic depression, bi-polar disorder or Attention Deficit Hyperactivity Disorder
	13. Fibroid cystic breast or other breast disorders
	14. Fractures/Limb loss
	15. Gall stones or any other gallbladder disorder
	16. Gout
	17. Head, spinal cord injuries
	18. Heart or cardiovascular disorders, including, but not limited to, heart attack, heart murmur, irregular heart rate, valve disorders, angina or chest pain
	19. Hemophilia, anemia, sickle cell anemia, or other blood disorder
	20. Hepatitis – If yes, what type?
	21. Hypertension (high blood pressure)
	22. Intestinal disorders, including, but not limited to, diverticulitis, hernia, rectal disorders, colitis or Crohn's Disease
	23. Kidney disorders, including, but not limited to, kidney failure, kidney stones, bladder or genitourinary diseases or disorders, polycystic kidney disease, renal failure or on dialysis
	24. Liver disorders, including, but not limited to, cirrhosis
	25. Lupus, scleroderma, fibromyalgia, vasculitis, or any other connective tissue disorders

Employee Name:_____

Section 4: Medical History (con't.)

Yes	Condition
	26. Lung disorders, including, but not limited to, tuberculosis or emphysema
	27. Nervous system disorders, including, but not limited to, epilepsy, seizures, paralysis, multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's Disease
	28. Prostate, testicular, erectile dysfunction
	29. Reproductive disorders: abnormal uterine bleeding, fibroids, menstrual disorders, endometriosis, infertility, other
	30. Sleep Apnea
	31. Stroke or TIA (mini stroke)
	32. Thyroid, goiter, glandular diseases or disorders, pituitary, pancreatic, or disorder requiring growth hormone
	33. Ulcers, acid reflux or other disorders of the stomach

Have you or anyone listed on this form, in the last five (5) years, consulted or sought treatment, had treatment recommended, received treatment or therapy, been surgically treated, had surgery recommended, or been hospitalized for any medical condition or disorder not mentioned above?
❑ Yes ❑ No If yes, explain:

Are you or anyone listed on this form currently pregnant? ❑ Yes ❑ No IF YES, DUE DATE: / /

Any future surgeries or treatment discussed, planned or recommended in the next 12 months? ❑ Yes ❑ No
If you checked yes, please explain:

If you checked any of the conditions in Section 4, please provide full details on each medical condition below.

# Identifying Condition Checked in Section 4	Name of Person	Medical Condition or diagnosis (indicate specific location of injury)	Treatment/Degree of Recovery	Dates/Duration Degree of Recovery	Name, Address, and Phone No. of Treating Physicians or Facilities

Employee Name:_____

Section 4: Medical History (con't.)

List any prescribed medications (including fertility drugs) that you or any of your dependents are currently taking. Use additional papers if needed.

Name of Person	Medication/dose strength/# per day	For what condition?

Section 5: Certification and Enrollment

In connection with this application for coverage with the insurer(s)/HMO(s) identified below, I certify that I have read, or have had read to me, this completed form, and I realize that any false statement or misrepresentation in this form may result in loss or rescission of coverage. I acknowledge that all claims relating to such false statements or misrepresentations will become my responsibility if incurred after termination or as a result of rescission.

I understand and agree that the insurer(s)/HMO(s) will rely upon the above information and answers as the basis for establishing group premium rates for health care coverage.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurer(s)/HMO(s) or other organization, institution or person that has any knowledge of my health or the health of my spouse and/ or dependents as listed on this form to disclose such information to the extent permitted by law to the insurer(s)/HMO(s) for the purpose of compiling an accurate evaluation of this form and to establish group premium rates for the group. This authorization does not permit the use or disclosure of psychotherapy notes. Authorization to disclose information for the payment of claims is valid for the term of coverage and in connection with application for coverage, policy reinstatement or a request for change in policy benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand that I may be contacted by the insurer(s)/HMO(s) to obtain additional follow-up information on health conditions disclosed in Section 4 of this document for me and/or my covered dependents.

I understand that I or my authorized representative may receive a copy of this authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

Full and proper corporate name of Insurer(s)/HMO(s)

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Employee Signature: **Daytime Tel. No.** **Date**: / /