

Legal Name: PHA Group Benefit Trust  
Version: PHBT / SOH / 0808

## EMPLOYEE / DEPENDENT STATEMENT OF HEALTH

Please duplicate this form for each Employee to complete.

**Company Name:** \_\_\_\_\_

**IMPORTANT! READ THIS SECTION CAREFULLY:** You must answer all questions truthfully and thoroughly. The Plan, its insurers and the Plan Administrators reserve the right to rescind coverage on any covered person due to material misrepresentation, omission, and/or fraud as it relates to completing this form. **You will not be individually denied coverage or individually charged different rates as a result of your answers.**

**ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE/SHE IS FACILITATING A FRAUDULENT ACT AGAINST AN INSURER OR SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A MATERIALLY FALSE OR DECEPTIVE STATEMENT, MAY COMMIT A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS THE PERSON TO CIVIL AND CRIMINAL PENALTIES.**

**Coverage Applicable:** \_\_\_\_\_ Employee Only \_\_\_\_\_ Employee & Spouse \_\_\_\_\_ Employee & Child(ren) \_\_\_\_\_ Employee & Family

**EMPLOYEE / DEPENDENT INFORMATION** **EMPLOYEE SOCIAL SECURITY NO:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Please complete all information for all persons to be covered)

Last Name	First Name	MI	Relationship Employee Spouse/Child	Sex M/F	Height	Weight	Date of Birth	Full-Time Student Yes/No	Disabled Yes/No

**NOTE:** Full time students ages 19-25 must carry 12 credits per semester. Student certification required from accredited college.

- Do you have any family members who are covered under the plan that live at a different address? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please provide legal documentation, name and address: \_\_\_\_\_
- Please provide family members covered by Medicaid and their effective date: \_\_\_\_\_
- Please provide family members covered by Medicare and their effective date: \_\_\_\_\_
- If you have Medicare, are you covered by: Part A: \_\_\_\_ Yes \_\_\_\_ No Part B: \_\_\_\_ Yes \_\_\_\_ No
- Do any family members intend to keep other health coverage in addition to this plan? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please provide the name of the insurance company and the policy number: \_\_\_\_\_

### PRIOR MEDICAL / DENTAL COVERAGE INFORMATION

**IMPORTANT!** You may be eligible for pre-existing condition limitation credit. Failure to provide the following information may result in a reduction or delay in payment of benefits.

- Have you and/or any dependents applying for coverage been covered by this employer's group medical plan? \_\_\_\_ Yes \_\_\_\_ No  
\_\_\_\_ Self \_\_\_\_ Dependents \_\_\_\_ More than 12 consecutive months? \_\_\_\_ Less than 12 consecutive months?  
Date coverage effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- If not, have you and/or any dependents applying for coverage been covered by any other medical plan? \_\_\_\_ Yes \_\_\_\_ No  
If yes, please provide certificate(s) of creditable coverage.  
Type of plan: \_\_\_\_ Spouse's Employer Group Plan \_\_\_\_ Prior Employer Group Plan \_\_\_\_ Individual Policy \_\_\_\_ Other  
Insurance Company Name: \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Reason for termination: \_\_\_\_\_ Termination Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**MEDICAL INFORMATION**

(Please provide details to any "Yes" answers below. Provide answers for employee, spouse, and dependents desiring coverage)

1. Within the past 5 years, have you or any of your dependents ever been diagnosed as having been advised to seek treatment for:

**Check all that apply:**

- Cancer, Tumor, polyp, cyst
- Brain disorder, mental or emotional disorder, seizures
- Fertility - IVP
- Blood disorder, circulatory, or vascular disorder
- Pregnancy (or expectant father) Date \_\_\_ / \_\_\_ / \_\_\_
- Kidney or liver disease
- Digestive disorders, reflux, gallbladder disorders
- Muscular or systemic disease, multiple sclerosis, lupus, arthritis
- Diabetes I or II, thyroid disorders
- Lung disorder, asthma, emphysema
- Back, neck joint disorder or replacement
- AIDS or HIV, Hepatitis
- Organ or bone marrow transplant (received or recommended)
- Hypertension, high cholesterol, heart attack,
- Drug or alcohol abuse
- Diagnostic procedure(s) or surgery (received, scheduled or recommended)
- Heart disease, strokes
- Other adverse health conditions

2. Have or are you or any of your dependents (spouse and/or child(ren)):

- a. Contemplating any surgery or hospitalization, testing or diagnostic procedures for any existing conditions? \_\_\_ Yes \_\_\_ No
- b. Pregnant? \_\_\_ Yes \_\_\_ No      If yes, due date: \_\_\_ / \_\_\_ / \_\_\_
- c. Currently taking or have been prescribed medications within the last 12 months? \_\_\_ Yes \_\_\_ No
- d. Currently taking an injectable drug? \_\_\_ Yes \_\_\_ No
- e. Currently being treated for any condition not listed above? \_\_\_ Yes \_\_\_ No
- f. Within the last 12 months, incurred medical expenses in excess of \$10,000? \_\_\_ Yes \_\_\_ No
- g. Scheduled or waiting for results of any tests, biopsies, procedures or lab work? \_\_\_ Yes \_\_\_ No
- h. Within the last 12 months, been advised or recommended for tests, hospitalization or surgery? \_\_\_ Yes \_\_\_ No
- i. Within the last 12 months, had medical or surgical consultation, advice or treatments for any condition(s) (including medication, psychological counseling or therapy)? \_\_\_ Yes \_\_\_ No
- j. Within the last 12 months, been advised of any abnormal test results or laboratory findings? \_\_\_ Yes \_\_\_ No

**Provide details to any "YES" or "Checked" answers listed above (If more space is needed, attach an additional sheets, sign and date.)**

Question No.	Name	Condition	Date condition began and treatment dates	Medications (Frequency & Dosage) / Treatment (Diagnosis & Prognosis) / Surgery / Treating Physician

I understand that the answers given above shall be the basis for the Plan to issue a proposal for medical benefits for my employer. I declare all statements contained in the this entire form are true and correct and that no material information has been withheld or omitted. I agree that no coverage will be effective until the date specified by the Plan Administrator. **This form will become part of the application for coverage at time of enrollment.** I hereby authorize any physician, medical practitioner, hospital, clinic, Veterans Administration facility, other medical or medically related facility, insurance or reinsurance company or Consumer Reporting Agency, having information available as to diagnosis, treatment, prognosis with respect t any physical or mental condition, including drug or alcohol abuse and/or treatment of me and my minor children and other non-medical information of me and my minor children, release to the Plan Administrator, any and all such information. I understand that I may request a copy of this authorization at any time, and agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall be valid for (1) year from the date shown above. I understand the information obtained by use of this authorization may be used by the Plan Administrator for health benefit underwriting. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes or as may be otherwise lawfully required or as I may further authorize.

By signing below, I agree that any additional information must be provided. I further understand and agree that failure to answer these questions completely and truthfully may result in loss of coverage for any or all those persons included on this application.

<b>Employee Name:</b>	<b>Employee Signature:</b>	<b>Date:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Address:</b>	<b>City/State/ Zip:</b>	<b>Email:</b>

**Based on information provided, you may be contacted by a physician for a brief telephone interview.**