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# Ohio Uniform Small Group Employee Application

This uniform application is intended to simplify the health insurance application process when your employer has requested quotes from multiple carriers. Although one application is being used for multiple carriers, ultimately one carrier, selected by your employer, will provide the coverage.

Section A: Employer Information

Section D: Waiver of Coverage

Section G: Other Coverage

Section B: Employee Information

Section E: Coverage Selected

Section H: Medical Information

Section C: Family Information

Section F: Beneficiary Designation

Section I: Authorization and Certification

**Section A: Employer Information**

Employer Name \_\_\_\_\_

Proposed Effective Date \_\_\_\_\_ Group Number (if known) \_\_\_\_\_

**Section B: Employee Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_ Sex \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height/Weight \_\_\_\_\_

Home Address \_\_\_\_\_

Home City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Work Address \_\_\_\_\_

Work City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

Email Address \_\_\_\_\_

Job Title \_\_\_\_\_ Full Time Date of Hire \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired

COBRA/State Continuation: Start Date \_\_\_\_\_ End Date \_\_\_\_\_

Hours Worked/Week \_\_\_\_\_ Salary \$ \_\_\_\_\_ per  Week  Month  Year  Other \_\_\_\_\_

Select all that apply:  Hourly  Salaried  Union  Non-Union

Marital Status:  Single  Married  Divorced  Widowed  Legally Separated

PCP Selection (if HMO or POS) \_\_\_\_\_ Are you an existing patient?  Yes  No

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

**In completing this application and answering the question set forth herein, you should not include any of your or your dependent's family history or genetic information (including, but not limited to, genetic testing, genetic services, genetic counseling, or genetic diseases for which you and/or your dependents may be at risk.)**

**Section C: Family Information (Attach legal documentation for court-ordered dependents)**

**Spouse**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_ Sex \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

PCP Selection (if HMO or POS) \_\_\_\_\_ Are you an existing patient?  Yes  No

**Child**  **Stepchild**  **Other** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_ Sex \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

PCP Selection (if HMO or POS) \_\_\_\_\_ Are you an existing patient?  Yes  No

Different Last Name  Lives at another address  Disabled +26  Full Time Student +26, please list

School Attending & Credit Hours \_\_\_\_\_

**Child**  **Stepchild**  **Other** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_ Sex \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

PCP Selection (if HMO or POS) \_\_\_\_\_ Are you an existing patient?  Yes  No

Different Last Name  Lives at another address  Disabled +26  Full Time Student +26, please list

School Attending & Credit Hours \_\_\_\_\_

**Child**  **Stepchild**  **Other** \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_ Sex \_\_\_\_\_

Social Security \_\_\_\_\_ Date of Birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

PCP Selection (if HMO or POS) \_\_\_\_\_ Are you an existing patient?  Yes  No

Different Last Name  Lives at another address  Disabled +26  Full Time Student +26, please list

School Attending & Credit Hours \_\_\_\_\_

**IMPORTANT:** Please provide an address on a separate sheet for dependents that do not live with the employee. Please see your employer for more information on qualifications for full time student status.

**Section D: Waiver of Coverage (Complete ONLY if you or your family are NOT enrolling)**

*I decline coverage for:*  Myself  Myself & all dependents  My spouse  Dependent Children as follows

*I decline coverage due to:*  Spouse's Employer Plan - Carrier & Group # \_\_\_\_\_

Individual Plan  Covered by Medicare  Covered by Medicaid  COBRA/State Continuation

*I have other coverage:*  VA Eligibility  Tri-Care  Other \_\_\_\_\_

I (we) have no other coverage at this time

I decline Medical coverage but request the following benefits offered by my employer \_\_\_\_\_

I understand that by waiving coverage at this time, I will not be allowed to participate unless I experience a qualified life change event; or I apply at the next open enrollment period or as a late enrollee, if applicable.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other insurance coverage, you may be able to enroll yourself or your dependents in this plan if: (1) you or your dependents lose eligibility for that other coverage or (2) the employer stops contributing towards your or your dependents' other coverage. However, you must request enrollment within 31 days after the applicable event occurs (other coverage ends or employer's contribution ends).

If you or your dependent either become eligible for premium assistance or lose eligibility for coverage under the State Children's Health Insurance Program (SCHIP), you will also be able to enroll in this plan. However, you must request enrollment within 60 days after such an event. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Employee Signature \_\_\_\_\_ Date Signed \_\_\_\_\_

**Section E: Coverage Selected**

PRODUCT	Medical	Dental (if applicable)	Life Insurance (if applicable)	Short Term Disability (if applicable)	Long Term Disability (if applicable)	Waiver
Employee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES
Dependents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> YES

For multiple options plans, please indicate plan selection below:

Medical \_\_\_\_\_ Dental \_\_\_\_\_

**Section F: Beneficiary Designation (Must be completed if you applied for Life or AD&D insurance)**

If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary (ies). If you list benefit percentages, the total must equal 100%. (The employee is the beneficiary of proceeds from spouse or child coverage.)

<b>Beneficiary</b>	<b>Full Name</b>	<b>Relationship</b>	<b>Benefit Percentage</b>
<b>Primary</b>			
<b>Contingent</b>			
<b>Contingent</b>			

**Section G: Other Coverage Information**

Does anyone identified on this application have current or prior coverage?  YES  NO

If yes, please provide proof of current coverage if you are waiving coverage or proof of prior coverage to ensure pre-existing condition credit. Acceptable forms of proof are:

1. Certificate of Creditable Coverage from prior carrier, or
2. Copy of ID card or most recent payroll stub showing medical coverage deduction, or
3. Copy of most recent medical premium bill from prior carrier.

Failure to provide Proof of Prior Coverage may subject you or a family member age 19 or older to the full pre-existing conditions limitation with no credit for prior coverage. You may request a Certificate of Creditable Coverage from your prior carrier.

Please identify each person applying for coverage and include information for all current and previous health coverage(s) in effect during the last 18 months.

<b>Applicant Name</b>	<b>Carrier Name</b>	<b>Group Number</b>	<b>Effective Date</b>	<b>Termination Date</b>	<b>Work Status</b>
					<input type="checkbox"/> Active <input type="checkbox"/> Retired
					<input type="checkbox"/> Active <input type="checkbox"/> Retired
					<input type="checkbox"/> Active <input type="checkbox"/> Retired
					<input type="checkbox"/> Active <input type="checkbox"/> Retired
					<input type="checkbox"/> Active <input type="checkbox"/> Retired

**MEDICARE**

Are you or any of your dependents covered by Medicare?  NO  YES, please attach a copy of your ID card

Medicare Beneficiary Name: \_\_\_\_\_

Medicare: Part A Effective Date \_\_\_\_\_ Part B Effective Date \_\_\_\_\_ Part D Effective Date \_\_\_\_\_

Reason:  Over 65  Disabled  End Stage Renal Disease  Disabled but actively at work

Type: Medicare Part A?  YES  NO Medicare Part B?  YES  NO Medicare Part D?  YES  NO

Ineligible or Waived: Medicare Part A?  YES  NO Medicare Part B?  YES  NO Medicare Part D?  YES  NO

Employee Last Name \_\_\_\_\_ Employee First Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Policy/Group#: \_\_\_\_\_ Section \_\_\_\_\_ Effective Date: \_\_\_\_\_

**Section H: Medical Information**

Have you or any other person listed on this application consulted with or been examined or treated by any health care professional during the last 5 years for any illness, injury or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the condition, record the specifics (if noted) and explain in detail on the table provided on page 12. **Please note, if you commit fraud or intentionally misrepresent a material fact, your coverage may be terminated, not renewed or premiums may be changed retroactively to the date your policy became effective.**

**1. HEART/CIRCULATORY/VASCULAR**

- YES, check all that apply and record specifics (if noted) below
- NO

**Condition**

<input type="checkbox"/> Cardiac Ablation Date: _____	<input type="checkbox"/> Congestive Heart Failure (CHF)
<input type="checkbox"/> Anemia Type: _____	<input type="checkbox"/> Elevated Cholesterol/Triglycerides
<input type="checkbox"/> Aneurysm Location: _____ Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Heart Attack/Disease (MI) Type: _____ Date: _____
<input type="checkbox"/> Angioplasty/Stent Date: _____	<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Blood Clot/Thrombophlebitis Location: _____	<input type="checkbox"/> Heart Valve Disorder
<input type="checkbox"/> Blood Disorder Type: _____	<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Bypass Date: _____	<input type="checkbox"/> Hypertension/High Blood Pressure
<input type="checkbox"/> CAD/Angina/Chest Pain	<input type="checkbox"/> Irregular Heart Beat/Arrhythmia Date: _____
<input type="checkbox"/> Carotid Artery Disease Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Pacemaker/ICD Implant Date: _____
<input type="checkbox"/> Peripheral Vascular Disease(PVD)	<input type="checkbox"/> Stroke/CVA Date: _____
<input type="checkbox"/> Varicose Veins Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT NEEDED	<input type="checkbox"/> Stroke Deficits Type: _____ Date: _____
<input type="checkbox"/> Other _____	

**2. BRAIN/NERVOUS SYSTEM/NEUROLOGICAL**

- YES, check all that apply and record specifics (if noted) below
- NO

**Condition**

<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/> Neurological Disability Type: _____
<input type="checkbox"/> ALS/Lou Gehrig's Disease	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Brain Injury Complications: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Paralysis Location: _____
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Concussion	<input type="checkbox"/> Seizures/Epilepsy Date Diagnosed: _____ Date of Last Seizure: _____ <input type="checkbox"/> Grand Mal <input type="checkbox"/> Petit Mal
<input type="checkbox"/> Head Injury	<input type="checkbox"/> Multiple Sclerosis/MS
<input type="checkbox"/> Migraines Last Visit to ER: _____	<input type="checkbox"/> Tumor/Growth/Cyst Location: _____
<input type="checkbox"/> Other _____	

### 3. BIRTH DEFECTS/CONGENITAL ABNORMALITIES

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> Cleft Palate/Lip	<input type="checkbox"/> Premature Birth <input type="checkbox"/> Still Receiving Treatment
<input type="checkbox"/> Club Foot	<input type="checkbox"/> Skull/Facial Deformities
<input type="checkbox"/> Developmental Delay	<input type="checkbox"/> Other Physical Deformities
<input type="checkbox"/> Down's Syndrome	<input type="checkbox"/> Webbed Fingers/Toes
<input type="checkbox"/> Heart Lung Malformation	<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Other _____	

### 4. URINARY/KIDNEY/BLADDER

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> Bladder Disorder	<input type="checkbox"/> Renal Failure/End Stage Renal Disorder Medicare Part A Eff. Date: _____ Medicare Part B Eff. Date: _____ Dialysis Start Date: _____
<input type="checkbox"/> Kidney Disorders	<input type="checkbox"/> Prostate Disorder    Type: _____
<input type="checkbox"/> Kidney Stone    Date: _____ Present: <input type="checkbox"/> YES <input type="checkbox"/> NO Number of Stones Passed: _____	<input type="checkbox"/> Tumor/Growth/Cyst Location: _____
<input type="checkbox"/> Polycystic Kidney Disease	<input type="checkbox"/> Other _____

### 5. INTESTINAL/DIGESTIVE

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Gastric Bypass/Stapling
<input type="checkbox"/> Colon Disorder	<input type="checkbox"/> Gall Stones
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> Metabolic Disorder Type: _____ Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Crohn's Disease Injections: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Reflux/GERD
<input type="checkbox"/> Feeding Tube	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Ileostomy/Colostomy <input type="checkbox"/> Open <input type="checkbox"/> Closed	<input type="checkbox"/> Tumor/Growth/Cyst Location: _____
<input type="checkbox"/> Colon Resection <input type="checkbox"/> Total <input type="checkbox"/> Partial <input type="checkbox"/> Open <input type="checkbox"/> Closed	<input type="checkbox"/> Ulcerative Colitis Injections: <input type="checkbox"/> YES <input type="checkbox"/> NO Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Other _____	

### 6. PSYCHOLOGICAL

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> ADHD/ADD	<input type="checkbox"/> Current Counseling
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse <input type="checkbox"/> Cocaine <input type="checkbox"/> Heroin <input type="checkbox"/> Marijuana <input type="checkbox"/> Methadone <input type="checkbox"/> Morphine <input type="checkbox"/> Opiate <input type="checkbox"/> Prescription Drug <input type="checkbox"/> Other _____
<input type="checkbox"/> Alcohol Suicide Attempt Date: _____	<input type="checkbox"/> Inpatient Mental Health Stay
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Autism	<input type="checkbox"/> Suicide Attempt Date: _____
<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Bulimia
<input type="checkbox"/> Bipolar/Manic Depression	<input type="checkbox"/> Other _____

### 7. LUNG/RESPIRATORY

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> Allergies Injections: <input type="checkbox"/> YES <input type="checkbox"/> NO How Often: _____	<input type="checkbox"/> Pneumonia Date: _____
<input type="checkbox"/> Asthma <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe Date of Last ER Visit: _____	<input type="checkbox"/> Sarcoidosis
<input type="checkbox"/> Chronic Bronchitis Number of Episodes/Year: _____	<input type="checkbox"/> Sleep Apnea C-PAP: <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> COPD/Emphysema Oxygen: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> NOT NEEDED	<input type="checkbox"/> Tuberculosis Date: _____
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Tumor/Growth/Cyst Location: _____
<input type="checkbox"/> Other _____	

### 8. CANCER

YES, check all that apply and record specifics (if noted) below

NO

Condition	
<input type="checkbox"/> Bone	<input type="checkbox"/> Hodgkin's
<input type="checkbox"/> Brain	<input type="checkbox"/> Non-Hodgkin's
<input type="checkbox"/> Breast	<input type="checkbox"/> Metastasis to other organs
<input type="checkbox"/> Cervical or Uterine	<input type="checkbox"/> Ovarian
<input type="checkbox"/> Colon	<input type="checkbox"/> Prostate
<input type="checkbox"/> Leukemia Type: _____	<input type="checkbox"/> Testicular
<input type="checkbox"/> Liver	<input type="checkbox"/> Lymph Node Involvement
<input type="checkbox"/> Lung	<input type="checkbox"/> Chemotherapy Start Date: _____ End Date: _____
<input type="checkbox"/> Lymphoma	<input type="checkbox"/> Radiation Therapy End Date: _____ Stage: _____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Skin Type: _____



### 9. EARS/EYES/NOSE/THROAT/SKIN

YES, check all that apply and record specifics (if noted) below

NO

#### Condition

<input type="checkbox"/> Acne	<input type="checkbox"/> Cochlear Implants
<input type="checkbox"/> Acoustic Neuroma	<input type="checkbox"/> Deafness
<input type="checkbox"/> Burns <input type="checkbox"/> 1 <sup>st</sup> Degree <input type="checkbox"/> 2 <sup>nd</sup> Degree <input type="checkbox"/> 3 <sup>rd</sup> Degree	<input type="checkbox"/> Deviated Septum
<input type="checkbox"/> Cataracts Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Right Eye <input type="checkbox"/> Left Eye	<input type="checkbox"/> Eczema
<input type="checkbox"/> Chronic Ear Infections Operated: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Chronic Sinusitis	<input type="checkbox"/> Psoriasis Injections: <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Tumor/Growth/Cyst    Location: _____
<input type="checkbox"/> Other _____	

### 10. REPRODUCTIVE

YES, check all that apply and record specifics (if noted) below

NO

#### Condition

<input type="checkbox"/> Abnormal Pap Normal Follow Up Pap: <input type="checkbox"/> YES <input type="checkbox"/> NO Date: _____	<input type="checkbox"/> Infertility Dates of Treatment: _____
<input type="checkbox"/> Breast Cysts or Tumor	<input type="checkbox"/> Menstrual Disorders
<input type="checkbox"/> Breast Implants <input type="checkbox"/> Saline <input type="checkbox"/> Silicone	<input type="checkbox"/> Polycystic Ovarian Syndrome
<input type="checkbox"/> Current Pregnancy Due Date: _____ (MM/DD/YYYY) <input type="checkbox"/> Multiples Expected <input type="checkbox"/> Complications thus far/High Risk <input type="checkbox"/> Prior History of Complications <input type="checkbox"/> Prior Cesarean Delivery <input type="checkbox"/> Cesarean Delivery Planned	<input type="checkbox"/> Pregnancy Complications
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Sexually Transmitted Diseases
<input type="checkbox"/> Human Papillomavirus	<input type="checkbox"/> Other _____

### 11. IMMUNE

YES, check all that apply and record specifics (if noted) below

NO

#### Condition

<input type="checkbox"/> Chromosomal Disorder Type: _____	<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Immuno Deficiency	<input type="checkbox"/> Other _____
<input type="checkbox"/> Lupus <input type="checkbox"/> Discoid <input type="checkbox"/> SLE Systemic	

### 12. BONES/MUSCLES/JOINT

- YES, check all that apply and record specifics (if noted) below  
 NO

Condition	
<input type="checkbox"/> Back/Neck Disorder Treatment: _____	<input type="checkbox"/> Fracture <input type="checkbox"/> Pins/Screws/Plate <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary
<input type="checkbox"/> Bulging/Herniated Disc Treatment: _____	<input type="checkbox"/> Joint Injury/Replacement Location: _____ Arthroscopy Date: _____ Replacement Date: _____
<input type="checkbox"/> Chronic Fatigue Syndrome	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Congenital Problem	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Degenerative Disc Disease	<input type="checkbox"/> Physical Deformity
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Prosthetic Device Body Part: _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Implants Removed: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Spina Bifida <input type="checkbox"/> Occulta <input type="checkbox"/> Cystica
<input type="checkbox"/> Arthritis Type: _____ Injections: <input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Tumor/Growth/Cyst Location: _____
<input type="checkbox"/> Other _____	

### 13. ENDOCRINE

- YES, check all that apply and record specifics (if noted) below  
 NO

Condition	
<input type="checkbox"/> Adrenal Gland	<input type="checkbox"/> Hyperthyroid
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Graves Disease
<input type="checkbox"/> Diabetes Date Diagnosed: _____ Type: _____ <input type="checkbox"/> Diet <input type="checkbox"/> Insulin <input type="checkbox"/> Oral Medication <input type="checkbox"/> Other _____ Last 3 readings: _____ Complications: _____	<input type="checkbox"/> Hashimoto Disease
<input type="checkbox"/> Growth Hormones Date: _____	<input type="checkbox"/> Liver Disorder Type: _____
<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> Other _____ Date: _____ Treatment: _____	<input type="checkbox"/> Pituitary Disorder
<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Tumor/Growth/Cyst Location: _____	<input type="checkbox"/> Other _____

**14. PRESCRIPTION MEDICATION**

YES, check all that apply and record specifics (if noted) below

NO

**Condition**

Current Medication

Please detail name, condition and dosage in the table provided on page 12

Medications Taken within the Past Year

Please detail name, condition and dosage in the table provided on page 12

**15. TRANSPLANT**

YES, check all that apply and record specifics (if noted) below

NO

**Condition**

Organ

Type: \_\_\_\_\_ Date: \_\_\_\_\_

Other \_\_\_\_\_

Stem Cell

Planned/Recommended

Date: \_\_\_\_\_

**16. OTHER**

YES, check all that apply and record specifics (if noted) below

NO

**Condition**

Abnormal Test Results (Excluding HIV/AIDS testing)

Chiropractor Adjustments

Abnormal Physical Results

Physical Therapy

Wheelchair Bound

Occupational Therapy

Uses of Crutches or Walker

Speech Therapy

Workers Compensation Injury

Claim #:

Test Results Pending (Excluding HIV/AIDS testing)

Other \_\_\_\_\_

Type: \_\_\_\_\_

**17. Additional Medical Questions: Please explain full details for all “Yes” questions in the grid below.**

For you or any person that will be covered, please respond and provide details in the table provided:

A. Within the last 5 years, has anyone been told they have any other condition not listed above? YES NO

B. Do any of the conditions identified above involve the Bureau of Worker’s Compensation? YES NO

If YES, please include the claim number \_\_\_\_\_

C. Has anyone been advised to have surgery and/or further treatment NOT yet performed? YES NO

D. Has anyone been diagnosed with HIV/AIDS? YES NO

E. Has anyone received a positive test result for HIV/AIDS? YES NO

F. Is anyone expecting to be the parent of a child expected to be born in the next 9 months? YES NO

G. Does anyone currently use tobacco products? YES NO

H. Has anyone been hospitalized in the past 24 months? YES NO

**If you have checked “yes” to any conditions on previous pages, have any other medical conditions, or anticipate a future surgery or procedure not listed above, please explain below.**

Please give FULL DETAILS for all “YES” answers. If necessary, please attach, date, and sign additional pages for medical explanation details.

Question Number	Applicant Name	Condition/Diagnosis: Include start date	Treatment: Include dates	Names of Medications: all varieties	Ongoing Treatment	Physician’s Name

**Section I: Authorization and Certification**

• In connection with this application for coverage with the carrier(s) identified below, I certify that I have read, or have had read to me, this completed form, and I realize that any act of fraud or intentional misrepresentation of a material fact in this form may result in a loss or rescission of coverage. I acknowledge that all claims relating to such acts will become my responsibility if incurred after termination or effective date of rescission.

• I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, carrier's HMO or other organization, institution or person that has any knowledge of my health or the health of my spouse, dependents and/or eligible adult-age children as listed on this form to disclose such information to the extent permitted by law to the carrier(s) for the purpose of compiling an accurate evaluation of the medical information provided in section H and to establish premium rates for the group.

• I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug use and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

• I understand the authorization signed for the purpose of collecting information in connection with this application for an insurance policy shall remain valid for thirty (30) months from the date shown below. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original.

• I understand that I may be contacted by the carrier to obtain additional follow-up information on health conditions disclosed in this document for me, my spouse, dependents, and/or eligible adult-age children.

• I understand and agree that the carrier(s) identified below, will rely upon the information provided in this application as the basis for establishing group premium rates for health care coverage. I also acknowledge that I may be required to complete and sign an Additional Authorization and Disclosure Form for the carrier selected by my employer.

**Check name of carrier:**

- Aetna    AultCare    HealthAmerica    Medical Mutual of Ohio    Paramount    The Health Plan of the Upper Ohio Valley  
 UnitedHealthcare    SummaCare / Summa Insurance Company    Other \_\_\_\_\_

**The carrier name section must be completed in its entirety prior to the employee and spouse signatures. Please list additional carriers above.**

Print Employee Name: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Spouse Name: \_\_\_\_\_

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(If applicable & available)

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**