



Statement of Health for Consideration of Group Plan Coverage

COVERAGE

Application for coverage: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family	Social Security No. _ _ - _ _ - _ _ _ _	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced
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PERSONAL INFORMATION (Please Print)

EMPLOYEE NAME: _____ (Last) (First) (M.I.)	Employer: _____ Occupation: _____ Employer's location: _____
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ADDRESS	CITY	STATE	ZIP CODE	COUNTY
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MEDICAL INFORMATION (Please Print)

<i>If more room is needed, please use the back of this form.</i>	Sex	Relation to Employee	Birthday Mo/Day/Year
Name: (Last) (First) (M.I.)	M F		
Employee	<input type="checkbox"/> <input type="checkbox"/>		
Spouse	<input type="checkbox"/> <input type="checkbox"/>		
1) Child	<input type="checkbox"/> <input type="checkbox"/>		
2) Child	<input type="checkbox"/> <input type="checkbox"/>		
3) Child	<input type="checkbox"/> <input type="checkbox"/>		
4) Child	<input type="checkbox"/> <input type="checkbox"/>		

Employee: Height _____ ft. _____ in. Weight: _____ lbs.	Spouse: Height _____ ft. _____ in. Weight: _____ lbs.
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1. In the past 5 years, have you or any of your eligible dependents, been diagnosed with or treated for:

- | | | |
|---|---|---|
| <input type="checkbox"/> Infertility
<input type="checkbox"/> Growth Deficiency
<input type="checkbox"/> Hodgkin's Disease
<input type="checkbox"/> Counseling (Please provide details)
<input type="checkbox"/> Alzheimer's Disease
<input type="checkbox"/> Kidney, Bladder or Prostate Disorder
<input type="checkbox"/> Cancer/Tumor/Cysts/Growths
<input type="checkbox"/> Diabetes <input type="checkbox"/> Diet <input type="checkbox"/> Oral <input type="checkbox"/> Insulin
Current Blood Sugar _____ | <input type="checkbox"/> Nervous/Mental Disorders, Including Eating and Attention Deficit
<input type="checkbox"/> Any Disease affecting Muscle Control or Disorder of Bones/Joints
<input type="checkbox"/> High Blood Pressure - Current reading & date _____
<input type="checkbox"/> Respiratory Disorders including Allergies and Asthma
<input type="checkbox"/> Leukemia, Hemophilia or other Blood Disorders
<input type="checkbox"/> Heart Condition/Disease/Circulatory Disorder
<input type="checkbox"/> Ulcerative Colitis or Crohn's Disease
<input type="checkbox"/> Acquired Immunodeficiency Syndrome (AIDS)
<input type="checkbox"/> Acquired Immunodeficiency Related Complex | <input type="checkbox"/> Hydrocephalus
<input type="checkbox"/> Systemic Lupus
<input type="checkbox"/> Organ Transplant
<input type="checkbox"/> Liver Disorder
<input type="checkbox"/> Stroke or Seizures
<input type="checkbox"/> Eyes, Ears or Nasal Disorder
<input type="checkbox"/> Alcohol or Drug Abuse
<input type="checkbox"/> Human Immun.Virus (HIV)
<input type="checkbox"/> Other _____ |
|---|---|---|

"Disorder" is defined as a disease, illness, injury, and/or condition differing in any way from the usual or normal state and/or structure.

Yes	No	<input type="checkbox"/> <input type="checkbox"/> 2. In the past five years, have you or any of your eligible dependents, been hospitalized, had any surgery or medical insurance claim over \$2,000?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> 3. Do you, or any of your eligible dependents, have any treatment pending or have you been advised that treatment, hospitalization or surgery is needed?

4. Have any prescriptions been prescribed to you or have any of your eligible dependents taken any maintenance type prescription drugs in the last 3 years? If yes, list drug and last dosage date below.
- | | |
|--------------------------|-------------|
| <u>Prescription Drug</u> | <u>Date</u> |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
5. Are you or your eligible dependents, home, hospital or wheelchair confined, or do you have dependents who might be considered developmentally disabled or handicapped in any way?
6. Are you or your eligible dependents, currently pregnant?
7. Do you or any of your eligible dependents currently (or recently) smoke one or more cigarettes, cigars or pipe, or any form of tobacco including chewing tobacco? If "yes", how many years _____; date of last use _____.
8. Do you or any of your eligible dependents have any problems of the reproductive system including: abnormal Pap smear, vaginal bleeding, impotence, sexually transmitted disease, etc.

Please provide full details below for all "Yes" answers and any conditions marked for #1.* (Please Print)

Question Number	First Name	Description of illnesses, injury or pregnancy & medical treatment	Dates	Prognosis	Name and address of attending physician or hospital telephone number

*** If more room is needed, please use the back of this form.**

If the answer to any of the above questions is "yes," additional medical information may be required. WHP will notify you if additional information is required. It is important that all answers to questions be as correct and complete as possible. Failure to disclose all relevant information could result in claims being delayed or denied. Misstatements can also cause insurance coverage to be cancelled as if it never existed, so please take time to think about your answers.

WAIVER OF COVERAGE

Individuals who are waiving coverage (for themselves or their eligible dependents) during their open enrollment period must complete and sign this section of the health questionnaire. The reason for not requesting coverage through Welborn Health Plans must be clearly stated on this form. If you are electing to waive medical coverage, please read and signify your understanding by signing the following:

I, _____ (Print Name), understand and acknowledge that I am waiving coverage under Welborn Health Plans, and the failure to elect coverage during this initial enrollment period permits the plan to impose, should I later decide to elect coverage, restrictions that apply to "late enrollees":

- I refuse the following health care coverage:
- Employee, spouse and child(ren) coverage
 - Spouse coverage
 - Child(ren) coverage

- Reason for Refusal:
(Please check all appropriate boxes.)
- other group coverage sponsored by my employer
 - other group coverage sponsored by my spouse's employer
 - other reasons (please explain) _____

"Late Enrollee" means an eligible employee or a dependent of an eligible employee who has declined health coverage under a health benefit plan offered through employment or sponsored by an employer at the time of the initial enrollment period provided under the terms of the health benefit plan, and who subsequently required enrollment in a health benefit plan of that employer, provided that the initial enrollment period shall be a period of at least 30 days. Individuals who meet the following criteria will **not** be considered "late enrollees".

- Individuals who stated at the time of initial enrollment that coverage under another health insurance plan was the reason for declining enrollment; and they are now applying for coverage with Welborn Health Plans because coverage under the previous plan has terminated due to death or divorce of a spouse, termination of the other plan by an employer or the insurance carrier, termination of employment, reduction in the number of hours of employment, or termination of employer contributions towards the coverage; and such individuals are applying no later than thirty (30) days after the date of exhaustion of coverage.

2. Individuals whose employer offers multiple health insurance plans, and this individual is applying during Welborn Health Plans Open Enrollment period;
3. The individual is applying for dependent coverage in order to comply with a court order and makes application no later than thirty (30) days after the issuance of the court order; or
4. The individual stated at the time of initial enrollment that coverage under another health insurance plan was the reason for declining enrollment, whose coverage was under a COBRA continuation provision, the provision was exhausted and they are applying no later than thirty (30) days after the date of exhaustion of coverage.

I certify that Welborn Health Plans group medical coverage has been offered to me and my dependents and that my decision to refuse medical coverage is not due to any suggestion or pressure by my employer, the insurance agent or broker, any representative of Welborn Health Plans.

Signature of Employee: _____ Date: _____

CERTIFICATION

I CERTIFY that the answers given above are complete and true to the best of my knowledge. I understand that any misrepresentation, intentional or otherwise, as to the presence or absence of pre-existing medical conditions, impairments or diseases will void my membership and rights to benefits. I must report to Welborn Health Plans any change in my health status after I have submitted this questionnaire and prior to acceptance. Welborn Health Plans has the right to request information regarding any change in health status or impairment or disease which occurs between the date of the application and the acceptance date. The insured is not entitled to benefits until the membership premium is paid.

Signature of Employee: _____ Date: _____

NOTICE OF INSURANCE INFORMATION PRACTICES

During our review of your health questionnaire, it may be necessary to obtain personal information from sources other than yourself. You have the right to know what information we obtain about you. You may request, in writing, correction of any erroneous information. Although the information we obtain about you is confidential, we may disclose information to others without your specific authorization, as permitted by applicable law.

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I, _____ (print name), authorize any insurance company, hospital, medical or medically related facility, physician or other medical practitioner or any other organization, institution or person who has any past or present information about me, or my dependents' physical or mental health, including substance use or abuse, to release that information to Welborn Health Plans, its business associates and its underwriters. I understand that the privacy of any medical information released pursuant to this authorization will be maintained in accordance with applicable law. This authorization will be valid for twenty-four (24) months from the date of my signature. A photocopy of this authorization shall be as valid as the original. I am aware that I may obtain a copy of this authorization by a written request to Welborn Health Plans.

I understand that I have the right to revoke this authorization at any time by writing to WHP at the following address: 101 S.E. Third Street, Evansville, IN 47708. I understand that such revocation will not affect the uses and disclosures of such information which have occurred in reliance upon my authorization before WHP's receipt of a written revocation.

I understand that signing this authorization is voluntary and treatment will not be conditioned upon my signing this authorization. However, enrollment in WHP may be denied should I fail to sign this authorization.

Signature of Employee: _____ Date: _____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, or other person, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. Any person who knowingly and with intent to defraud any insurance company, or other person, conceals, for the purpose of misleading information concerning any fact material thereto may be subject to criminal prosecution, civil penalties, and/or termination of insurance.