

# Small Business Individual Health Statement Application

Source Code	Tracking #
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■ Type or Print in Black Ink ■ Please submit in a sealed envelope along with your completed Employee Enrollment Form

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

	First Name	Middle	Last	SS #	Date of Birth Mo - Day - Yr	Height	Weight	Sex
Employee								
Spouse/ Domestic Partner								
Child								
Child								
Child								

**FOR ANY "YES" ANSWERS, PLEASE GIVE DETAILS IN THE SECTION PROVIDED BELOW**

- Is any female to be covered currently pregnant?  Yes  No
  - If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application?  Yes  No
  - If yes to "a" or "b", is there current or a history of complications or multiple gestation birth?  Yes  No
- In the last five years, have you or any eligible dependents incurred a claim in excess of \$5,000?  Yes  No
- Within the past five years, has any person to be insured been diagnosed or treated by a physician or member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?  Yes  No
- Is any person to be insured disabled, hospital confined, receiving treatment, taking medication, or been advised of a condition that will require attention or routine follow-up in the next 24 months?  Yes  No
- Within the past five years, has any person to be insured been diagnosed, had symptoms, had testing completed, had treatment, taken medications or had routine follow-up for any of the following: Cancer/Tumor, Diabetes, Heart/Blood/Vascular Disorder, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory-Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants, or Mental or Emotional Disorder?  Yes  No
- Are you currently on continuation coverage from a former employer?  Yes  No  
If "Yes":  Federal COBRA  Cal-COBRA

**For groups enrolling 2-10 employees or late enrollees, complete the following Additional Medical History Section below.**

Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for...

A. Alcohol/Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	G. Digestive/Eating Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	M. Muscle Disorder/Neurological Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Arthritis/Back/Joint Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	H. Ear/Eye Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	N. Skin Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Asthma/Tobacco Usage	<input type="checkbox"/> Yes <input type="checkbox"/> No	I. Epilepsy/Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	O. Thyroid/Adrenal Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
D. Blood Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	J. Genital/Urinary Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No	P. Tuberculosis/Hepatitis A, B or C	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Breast Disorder or Breast Implants	<input type="checkbox"/> Yes <input type="checkbox"/> No	K. High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Q. Sleep Apnea	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Congenital Disorder or Deformity	<input type="checkbox"/> Yes <input type="checkbox"/> No	L. Infertility	<input type="checkbox"/> Yes <input type="checkbox"/> No	R. Systemic Infection	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Detailed Answers to Questions 1-5 and the Additional Medical History Section**

- Pregnant persons and expected due dates: \_\_\_\_\_
- Provide full details to all "Yes" answers noted above. Attach a separate page if necessary.

Eligible Person	Nature of Illness/Injury	Month/Year	Medication/ Treatment	Recovered? (Yes or No)	Explanation/Comments
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	

**Authorization**

I agree: All information on this form is correct and true, to the best of my knowledge and belief. I further authorize my employer to deduct from my earnings any contribution required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week (or 20-29 hours per week if elected by my employer).

On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

Employee Signature	Date
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