



**Health Statement**  
**Health Core Services**  
**Aetna Life Insurance Company**

Employee's Name	Control Number	Employee's Social Security Number
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1. **Only the Names of Individual(s) Requesting Coverage at this Time Should be Listed.**  Check here if additional dependent children are listed on a separate attachment. (Be sure to include their sex, birthdate, height and weight.)

Name	Sex	Birthdate	Height (ft., in.)	Weight (lbs.)
Employee:	<input type="checkbox"/> M <input type="checkbox"/> F			
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F			
Dependent Children:	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

2. **Statement of Health for Individual(s) Listed Above.** Give complete dates and details for all "Yes" answers and/or medical impairments checked using the space provided after Question 16.

<input type="checkbox"/>	<input type="checkbox"/>	1.	Is diagnostic testing or an operation recommended or contemplated for anyone?
<input type="checkbox"/>	<input type="checkbox"/>	2.	Is anyone pregnant?
<input type="checkbox"/>	<input type="checkbox"/>	3.	Is anyone taking any medication or receiving any treatment? If "Yes", list individual(s), all medications and dosages, and indicate the underlying condition and/or type of treatment of being received.
<b>Within the past 3 YEARS, has any individuals:</b>			
<input type="checkbox"/>	<input type="checkbox"/>	4.	Had accident, health or life insurance modified, postponed, rated or declined? If "Yes", give complete details.
<input type="checkbox"/>	<input type="checkbox"/>	5.	Been diagnosed with or treated for chest pain, blood pressure, heart attack, or other diseases of the heart or blood vessels (circulatory system)?
<input type="checkbox"/>	<input type="checkbox"/>	6.	Been treated for mental, emotional or nervous disorder or depression?
<input type="checkbox"/>	<input type="checkbox"/>	7.	Been treated for cancer, tumor or other malignancy?
<input type="checkbox"/>	<input type="checkbox"/>	8.	Been treated for stroke, TIA (mini-stroke) or paralysis?
<input type="checkbox"/>	<input type="checkbox"/>	9.	Been treated for emphysema, other respiratory or lung diseases or breathing conditions?
<input type="checkbox"/>	<input type="checkbox"/>	10.	Been treated for diseases of the kidney, pancreas or liver?
<input type="checkbox"/>	<input type="checkbox"/>	11.	Been treated for or diagnosed as having immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus ("HIV") or other immune system disorders?
<input type="checkbox"/>	<input type="checkbox"/>	12.	Been diagnosed with diabetes? If "Yes", give date of diagnosis and whether insulin or non-insulin dependent. Please include dosage of insulin and any related problems.
<input type="checkbox"/>	<input type="checkbox"/>	13.	Been treated for arthritis? If "Yes", specify type, extent of disability and treatment received.
<input type="checkbox"/>	<input type="checkbox"/>	14.	Been confined in a hospital, clinic, sanitarium or other medical facility?
<input type="checkbox"/>	<input type="checkbox"/>	15.	Had any disease or impairment of or treatment for any of the following? If "Yes", check the appropriate box(es) below and explain using the space provided.
<input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Bone/Joint <input type="checkbox"/> Epilepsy <input type="checkbox"/> Infertility <input type="checkbox"/> Lupus <input type="checkbox"/> Skin <input type="checkbox"/> Other <input type="checkbox"/> Back/Neck <input type="checkbox"/> Brain <input type="checkbox"/> Ears/Eyes <input type="checkbox"/> Intestines <input type="checkbox"/> Migraines <input type="checkbox"/> Stomach <input type="checkbox"/> Blood <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Neurological <input type="checkbox"/> Venereal Disease			
<input type="checkbox"/>	<input type="checkbox"/>	16.	Does anyone have any known physical impairment or ill health not mentioned above? If "Yes", give complete details below.

**USE this space to provide complete dates and details for all "Yes" answers and/or medical impairments checked above.**

Indicate the number of the question and provide the **Name of the Individual, Nature of the Disorder/Injury, Dates and Type if Treatment, and Current Condition.** Please include additional information as requested in Questions 3, 4, 12, 13, 15 and 16.

Indicate here if additional information is on a separate attachment.

**Certification:** I certify that these answers and statements are complete and true to the best of my knowledge and belief. I agree that this document shall form a part of my request for insurance and I acknowledge that I have been given a copy of this document as completed by me. I understand that the information provided will not effect my eligibility to participate in this plan.

	Employee's Signature
Date Signed                      City                      State	Spouse's Signature (Required if spouse coverage is being requested.)
at	