



HEALTH STATEMENT

For Groups with less than 14 Eligible Employees

EMPLOYEE NAME	LAST	FIRST	M.I.
EMPLOYER NAME			

Answer the following questions about yourself or any family member applying for coverage. **Give details for any yes responses** in the section below.

1. During the past 12 months have medical expenses in excess of \$10,000 been incurred? YES NO
2. Is anyone currently pregnant? YES NO Expected delivery date?
C-section planned? YES NO
3. Does anyone have any chronic medical conditions, such as diabetes, hypertension, cancer, heart condition, lung disease, kidney disorder or AIDS/ARC? YES NO
4. Has anyone had surgery or been hospitalized in the last 5 years? YES NO
5. Is surgery or hospitalization anticipated within the next 6 months? YES NO
6. Is anyone currently disabled or has been disabled in the last 2 years? YES NO
7. Is anyone currently taking medication? YES NO

1. Height _____	Weight _____	Height _____	Weight _____
EMPLOYEE		SPOUSE	

Question # _____	Name of person treated: _____
	Diagnosis/condition: _____
	Type of Treatment: _____
	Type of Treatment: _____ Date treatment ended: _____
	Testing (laboratory/radiology, findings): _____
	Medication/dosage: _____
	Hospitalized (reason/dates): _____
	Degree of recovery (any residuals, continued treatment?) _____

	Name and address of physician or practitioner: _____

Question # _____	Name of person treated: _____
	Diagnosis/condition: _____
	Type of Treatment: _____
	Type of Treatment: _____ Date treatment ended: _____
	Testing (laboratory/radiology, findings): _____
	Medication/dosage: _____
	Hospitalized (reason/dates): _____
	Degree of recovery (any residuals, continued treatment?) _____

	Name and address of physician or practitioner: _____

IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE STATEMENT. BE SURE TO SIGN AND DATE YOUR ATTACHEMENT.

I certify that these answers and statements, including those on any attachments, are complete and true to the best of my knowledge and belief I understand that this document shall form a part of my request for health coverage. I understand that any fraudulent or other material misstatements or omissions I make on this form may result in cancellation or ten-nation of coverage for me and my dependents.

I authorize any "provider of health care" to disclose to Western Health Advantage or their designated agents, all "medical information" (as these terms are defined in the Civil Code), including all mental/emotional disorders, pertaining to me. This information is collected for the purposes of evaluation my application. This authorization will remain valid for 30 months from the date below. A photocopy of this authorization is as valid as the original. My authorized agent or I am entitled to receive a copy of this authorization.

SIGNATURE OF EMPLOYEE Date

SIGNATURE OF SPOUSE (if applying) Date