Employer Group Name							
Part 3 - HEALTH INFORMATION - continued							
4. Has any person to be covered by this plan ever been diagnosed with or tested positive for AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)? No Yes If Yes, then provide details in the Medical Details Section in Part 4.							
5. Is any person listed Part 1 of this form currently pregnant or an expectant parent? No Yes If Yes, then provide details in the Medical Details Section in Part 4.							
6. Has any person to be covered by this plan been advised to have future medical treatment or surgery? No Yes If Yes, then provide details in the Medical Details Section in Part 4.							
7. Has any person to be covered by this plan used tobacco products in any form within the past 5 years? No UYes If Yes, provide user's name(s) and date(s) of last use							
8. Has any person to be covered by this plan taken any prescription drugs not already noted within the past 5 years for any illness, injury or condition (excluding colds, flu and routine exams not related to a medical condition)? No Yes If Yes, then provide details in the Medical Details Section in Part 4.							
9. Has any person to be covered by this plan been examined or treated by a physician, psychotherapist, counselor, or other medical professional within the past 5 years for any illness, injury or condition not already noted (excluding colds, flu and routine exams not related to a medical condition)? No Yes If Yes, then provide details in the Medical Details Section in Part 4.							
Part 4 - MEDICAL DETAILS - Please provide complete details for all YES answers in Part 3. Attach additional sheets if necessary.							
Question Number	Family Member's Name	Condition or Reason	Treatment and/or Medication	Onset Date	Recovery Date	Degree of Recovery	Treating Physician Name, Address and Telephone
Part 5 - FAMILY HEALTH STATEMENT CERTIFICATION							
I represent that all statements and answers I have given are complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. I will promptly inform the insurance carrier in writing before my coverage takes effect if I become aware that anything has occurred that makes this family health statement incomplete or incorrect. I understand that I or any other adult to be covered by this policy may be contacted for additional information or asked to sign an authorization for the release of medical records. Health care providers listed on this form will not be contacted unless you or your dependent signs a separate written medical authorization.							
Employee Printed Name			Employee Signature			Date	Daytime Phone Number

Employee Signature

Employee Printed Name