

STATEMENT OF HEALTH

Important: Please print or type all sections in black ink

New Enrollment Transfer from HMO to PPO Coverage Other _____

A. Employer Information	
Employer	Group #

This Statement of Health is for: Employee Spouse Child

B. Employee and Dependent Information					
Name	Date of Birth	Sex	Height (feet-inches)	Weight	Used tobacco in last 12 months?
Employee		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
Spouse		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
Child		<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N

If more Dependents are enrolling, attach a separate sheet of paper. Sign and date all additional papers.

C. Medical Information

The medical information on this form may not be used to deny coverage to the individuals applying for coverage.

Answer questions 1 through 10 with respect to the employee and Dependent(s) for any condition which has been treated in the last five years. If the answer to any question is yes, give details in the space provided below.

- | | | |
|--|--|---|
| <p>1. Have you or a Dependent been treated for or had any known indications of: (in addition to checking yes or no, circle the applicable condition/s in each question)</p> <p>1a. Disease or disorder of eyes, ears, nose or throat? <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>1b. Dizziness, fainting, convulsions, paralysis or stroke; mental or nervous disease or disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>1c. Shortness of breath; blood spitting; bronchitis or other chronic respiratory disease or disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>1d. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart or blood vessels? <input type="checkbox"/> <input type="checkbox"/>
 If you answer yes to 1d, please complete the Supplementary Medical Information (Sections 1 and 3) on the reverse side of this form.</p> <p>1e. Ulcer, hernia, colitis, intestinal bleeding; jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gall bladder? <input type="checkbox"/> <input type="checkbox"/></p> <p>1f. Sugar, albumin, blood or pus in urine; stone or other disease or disorder of bladder, prostate or reproductive organs? <input type="checkbox"/> <input type="checkbox"/></p> <p>1g. Disorder of the kidney or kidney disease? <input type="checkbox"/> <input type="checkbox"/>
 If you answer yes to 1g, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.</p> <p>1h. Cancer, cyst or tumor? Undergone chemotherapy or radiation treatment? <input type="checkbox"/> <input type="checkbox"/>
 If you answer yes to 1h, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.</p> | <p>1i. Diabetes; thyroid or glandular disorder; skin disease or disorder? <input type="checkbox"/> <input type="checkbox"/>
 If you answer yes to 1i, please complete the Supplementary Medical Information (Sections 1 and 2) on the reverse side of this form.</p> <p>1j. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones, including the back or joints? <input type="checkbox"/> <input type="checkbox"/></p> <p>1k. Deformity, congenital anomaly, or amputation? <input type="checkbox"/> <input type="checkbox"/></p> <p>1l. Allergies; anemia, other blood or lymph disease or disorder? <input type="checkbox"/> <input type="checkbox"/></p> <p>1m. Disorder of menstruation, infertility, pregnancy, multiple or premature births, female organs or breasts? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>2. Have you or a Dependent been treated for or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or any AIDS-related condition? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>3. Are you or a Dependent now under observation or treatment by a physician or practitioner? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>4. Have you or a Dependent been evaluated or considered for any type of transplant? <input type="checkbox"/> <input type="checkbox"/>
 If you answer yes to question 4, please complete the Supplementary Medical Information (Section 1) on the reverse side of this form.</p> | <p>5. Other than as stated in answers to questions 1, 2, 3 and 4, have you or a Dependent within the past 5 years:</p> <p>5a. Been attended by physician/practitioner for consultation, examination, diagnosis or treatment? <input type="checkbox"/> <input type="checkbox"/> Y <input type="checkbox"/> N</p> <p>5b. Been a patient in a hospital, clinic or other medical facility? <input type="checkbox"/> <input type="checkbox"/></p> <p>5c. Had electrocardiogram, X-ray or other diagnostic test? <input type="checkbox"/> <input type="checkbox"/></p> <p>5d. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>6. Have you or a Dependent been addicted to alcohol, drugs or any other substance? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>7. Have you or a Dependent been advised of an elevated cholesterol problem? <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>8. Are you or a Dependent currently pregnant? . . <input type="checkbox"/> <input type="checkbox"/></p> <hr/> <p>9. Within the past two (2) years, has any person listed above had any symptoms of, or received medical or surgical advice or treatment for any serious or chronic condition other than mentioned above? <input type="checkbox"/> <input type="checkbox"/></p> |
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Question #	Covered Person: Employee, Spouse or Child	Disease/ Diagnosis	Onset MM/YY	Duration	Treatment and result (mention any surgery performed)	Names of Physicians/Hospitals

10. Does any applicant listed on this application currently take prescription drugs?
 If yes, list applicant's name(s), drug name(s), dosage and date started

Applicant's Name	Drug	Dosage	Date Started
Applicant's Name	Drug	Dosage	Date Started
Applicant's Name	Drug	Dosage	Date Started

D. Authorization

1. **I agree:** All information on this form is correct and true.

2. **Authorization to obtain or release medical information:**

I hereby authorize any health care facility, physician or surgeon, or any other health care professional to disclose to PacifiCare, its agents or employees, all information from my medical records pertaining to any past or future examination or treatment including treatment for substance abuse and mental and emotional disorders (except psychotherapy notes) furnished to me or my dependents who are also applying for this coverage, and to any illness, injury or condition that I or these dependents have had at any time. PacifiCare requests this information to conduct underwriting and risk rating activities so PacifiCare can determine your eligibility and, if applicable, determine the rates offered to you for coverage. I understand that if my information is shared with someone who is not required to follow state or federal privacy laws, my information may no longer be protected. I understand that I am entitled to receive a signed copy of this authorization. I understand that this authorization shall be valid for 30 months from the date of my signature, and a photocopy or other reproduction of this authorization is as valid as the original. If you refuse to provide this authorization, PacifiCare will not make an eligibility determination, and you will not be considered for membership of a PacifiCare plan. I understand that I may revoke this authorization at any time before I become a PacifiCare Member, except for instances where PacifiCare has already taken action based on the authorization. I agree to send my written revocation to PacifiCare Underwriting, M/S CO 84-441, 6455 South Yosemite Street, Greenwood Village, CO 80111. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety. Please note an additional valid authorization or Power of Attorney is required for personal representatives.

Employee Signature	Date
Name of Custodian or Personal Representative (If applicable)(Please print)	Date

SUPPLEMENTAL MEDICAL INFORMATION

Important: Please print or type all sections in black ink. If more space is required, use an additional form or separate sheet of paper. Please sign and date all additional pages.

I. Answer the following only if questions 1d, 1g, 1i, or 4 on the Statement of Health were answered with a "Yes".

Employee Name	Employer
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The Statement of Health is for: Employee Spouse Child

1. Diagnosis or symptoms: _____
2. Underlying cause: _____
3. Age and date diagnosed: _____
4. Date first treated: _____
5. What type of treatment was performed? Provide dates of treatment. _____

6. Have there been any hospitalizations or emergency room treatments in the last five years? If yes, dates and reason for confinement/visit. _____

7. Are there any complications or residual problems? If so, please describe. _____

II. Diabetic Applicants

If question "1i" on the Statement of Health was answered with a "YES," answer the following questions in addition to 1-7 above.

8. Type of Diabetes: ___ Type 1 ___ Type II Units of Insulin per day _____
Date of Onset _____
9. Is there any history of eye, kidney, cardiovascular, circulatory or skin disorders? If so please describe, including date of occurrence, treatment and present condition. _____

III. Cardiac/Circulatory/Elevated Blood Pressure Applicants

If question "1d" on the Statement of Health was answered with a "YES," answer the following questions in addition to 1-7 above.

10. In the last five years, have you had a heart attack? If yes, provide date of attack, dates of hospitalization, was any surgery performed, pending or recommended? _____

11. Have you been treated in the last five years for any other heart condition? If yes, provide condition, date of onset and treatment. _____

IV. Signature

Employee Signature	Date
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