



## GROUP HEALTH STATEMENT

School District Name: \_\_\_\_\_ Employee Name: \_\_\_\_\_ Employee Date of Birth: \_\_\_\_\_

Mark the box that pertains to your level of coverage.

Single	Two-Party	Parent/Child(ren)	Family	Retiree Single	Retiree Two-Party	Retiree Family	Medicare Single	Medicare Two-Party	Medicare 1+1-/65*

\* One member over age 65 and one under 65

1. In the last six months have you or your dependents had an illness or injury that required medical attention?    Yes                       No

If yes to question one, please complete the following (attach an additional sheet if needed):

Patient Name	Condition	Treatment Date	Hospitalization Date	Degree of Recovery	Medication Prescribed

2. In the last six months, have you or any of your dependents

- A) Consulted with or been treated by a physician or other health care practitioner?    Yes                       No
- B) Taken, or been advised to take, prescription drugs?    Yes                       No
- C) Had a diagnosis of or been treated for any of the following:
  - 1. Disease or disorder of the brain, nerves, lungs, heart, stomach, gallbladder, kidneys, reproductive organs    Yes                       No
  - 2. Hernia, hemorrhoids, high blood pressure, cancer, diabetes, AIDS/ARC    Yes                       No
  - 3. Alcohol or drug dependency    Yes                       No
  - 4. Any other physical or mental disease or impairment    Yes                       No
  - 5. Any serious or permanent injuries    Yes                       No

If yes to question two (A), (B), and/or (C), please complete the following (attach an additional sheet if needed):

Patient Name	Condition	Treatment Date	Hospitalization Date	Degree of Recovery	Medication Prescribed

3. Have you or any of your dependents had any medical claim over \$5,000.00 in the past six months?    Yes             No

If your response to question three was yes, please complete the following (attach an additional sheet if needed):

Patient Name	Condition	Treatment Date	Hospitalization Date	Degree of Recovery	Medication Prescribed

**I have read the questions and answers on this application and acknowledge that the answers are complete and true to the best of my knowledge and belief. I understand that all information on this form is Protected Health Information and will only be sent to the MUST underwriter to establish a new business premium quote and will not be shared with my employer or any other person.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_