



GROUP HEALTH STATEMENT

School District Name: _____ Full District Address: _____

Please complete the following:

	First Name	Last Name	Sex	Date of Birth	Height	Weight	Currently Insured? (Y/N)	Medicare Eligible? (Y/N)
Employee								
Spouse								
Child								
Child								
Child								

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

- a. Consulted with or been treated by a physician or other healthcare practitioner? Yes ___ No ___
- b. Taken, or been advised to take, prescription drugs? Yes ___ No ___
- c. Been diagnosed with or received medical care for any of the following?

- | | | | |
|---|----------------|--|----------------|
| AIDS/ARC/HIV or disorder of immune system | Yes ___ No ___ | Hepatitis, Cirrhosis or other liver disorder | Yes ___ No ___ |
| Cancer, anemia or tumor of any kind | Yes ___ No ___ | Spinal Cord Injury or disorder | Yes ___ No ___ |
| Heart disorder of any kind | Yes ___ No ___ | Amputation or burns | Yes ___ No ___ |
| Circulatory or blood disorder | Yes ___ No ___ | Hemophilia or other coagulation disorder | Yes ___ No ___ |
| Diabetes | Yes ___ No ___ | Alcohol/Chemical/Drug dependency | Yes ___ No ___ |
| Emphysema/COPD or other lung disorder | Yes ___ No ___ | Nervous/Mental/Depressive disorder | Yes ___ No ___ |
| Respiratory arrest or failure | Yes ___ No ___ | Neurological or seizure disorder | Yes ___ No ___ |
| Congenital anomaly/birth defect/premature birth | Yes ___ No ___ | Osteo/Rheumatoid arthritis | Yes ___ No ___ |
| Lupus, Multiple Sclerosis or systemic disorder | Yes ___ No ___ | Back or Knee disorder | Yes ___ No ___ |
| Cerebral disorder (CP, CVA, Guillain-Barre,ALS) | Yes ___ No ___ | Kidney disorder or renal failure | Yes ___ No ___ |
| Organ, bone marrow or stem cell transplantation | Yes ___ No ___ | Cystic Fibrosis | Yes ___ No ___ |
| Colon or gastro-intestinal disorder | Yes ___ No ___ | Weight Loss Procedure (gastric bypass) | Yes ___ No ___ |

2. If yes to question 1a, 1b, or 1c, 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 yes, please complete the following (attach an additional sheet if needed):

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

Authorization: I agree all of the information listed above is complete, accurate and true. I understand misstating or omitting known information may constitute insurance fraud and I further understand that I am providing this information to assist in analyzing my district's health benefit plan. 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:** _____