



## GROUP HEALTH STATEMENT

County or 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 participant over 65 and one under 65 yrs.

**If you answer “yes” to any of the questions below please complete information on page 2.**

1. In the last six (6) months have you or your dependents had an illness or injury that required medical attention? Yes  No
  
2. In the last six (6) 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
  
3. Have you or any of your dependents had any medical claim over \$5,000 in the past 6 months? Yes  No

**If “yes”, please complete information on page 2.**

**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.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

<b>Patient Name</b>	<b>Condition that Required Medical Attention</b>	<b>Treatment Date</b>	<b>Date of Hospitalization</b>	<b>Degree of Recovery</b>	<b>Medications Prescribed (with dosages)</b>