STATEMENT OF HEALTH OPTIMUM PLAN

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TO PROCESS YOUR ENROLLMENT, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

First Name: ______________________ Last Name: ______________________

Hospital: ______________________ Occupation: ______________________

General Information (Employee And Dependants)

Please complete the following information for all persons eligible for coverage including yourself, your spouse and all eligible dependants.

Relationship:	Name (First, Last):	Date Of Birth (MM/DD/YYYY):	Height (Ft/In):	Weight (lbs):	Smoker (Y/N):
Employee:					
Spouse:					
1st Child:					
2nd Child:					
3rd Child:					
4th Child:					

Statement Of Health Questionnaire

Have you or any of your dependants ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy, naturopathy, etc.) about, been treated for, or had any known indication of any of the following:

#	Question	Yes	No
1.	Circulatory, heart or vascular disease. High blood pressure, angina, stroke or TIA (mini stroke). Elevated cholesterol, chest pain or heart murmur?	☐	☐
2.	Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?	☐	☐
3.	Arthritis, gout, rheumatism, osteoporosis/osteopenia. Disorder of joints, limbs or spine. Joint or muscle pain?	☐	☐
4.	Skin disorder including acne, rosacea, psoriasis or eczema?	☐	☐
5.	Colitis, Crohn's, irritable bowel syndrome (IBS), ulcers, hernia, reflux or persistent heart burn?	☐	☐
6.	Infertility, reproductive disorder, menopause, disorder of breasts, ovaries, cervix or uterus?	☐	☐
7.	Stomach, intestinal, kidney, bladder or liver disorder including hepatitis?	☐	☐
8.	Headaches, migraines, dizziness, fainting, disorder of the brain or nervous system?	☐	☐
9.	Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures, paralysis ADD or ADHD?	☐	☐
10.	Sexually transmitted disease (STD) or infection (STI) or recurring infections (including cold sores or herpes)?	☐	☐
11.	Alcohol or drug dependency?	☐	☐
12.	Diabetes or endocrine disorder?	☐	☐
13.	Lung condition, respiratory condition including COPD, asthma, allergies or sleep apnea?	☐	☐
14.	Disorder of the eyes, ears, nose or throat?	☐	☐
15.	Cancer, tumor or any other growth?	☐	☐
16.	Anemia or low iron?	☐	☐
17.	Have you or any of your dependants ever been treated or hospitalized for or had any known indication or any physical impairment, condition, disease or disorder not stated above?	☐	☐
18.	Are you or any of your dependants currently taking prescription or non-prescription medications of any kind or been advised by a physician or alternative health care provider to take medication of any kind?	☐	☐
19.	Have you or any of your dependants ever been advised to have an investigation, hospitalization or surgery which has not yet been completed?	☐	☐

If you answered yes to any of the questions above, please provide additional details on the overpage, and circle which diagnosis or disorder applies to you or your dependants.

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Further Information Regarding Conditions From Overpage

If you answered yes to any of the questions on the overpage, please fill out the further details in the fields below and indicate the corresponding question number.

Question Number:	Name of Employee/Dependant (First, Last):	Injury or Condition:	Date of Onset & Recovery (MM/DD/YYYY):	Type of Medication or Treatment:	Approx. Monthly Cost of Medication:	How Often Do You See Your Doctor For Treatment:

Please note that based on your medical history, or that of a listed dependant, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the enrollment which this statement of health is a part of or acceptance of a counter offer.

Employee Declaration

I hereby declare that all the statements contained in this application for the Health Care Providers Group Insurance Plan™ are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility, or organization which has records of my or my dependants health to release such information to the plan administrator. I understand and agree that the information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand that it is my obligation to inform Health Care Providers Group Insurance Plan™ of a change in my health or that of my spouse or any listed dependant children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Health Care Providers Group Insurance Plan™ reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims. This form is valid ONLY 60 days from the date it is signed.

Dated ______________ (City/Town) **this** ________ (Day) **day of** ______________ (Month) **20** ________ (Year)

Signature of Employee: ______________________________

PRIVACY: All information about the insurability of you and your dependants is considered confidential. Health Care Providers Group Insurance Plan™ is a business name registered to HMA The BENEFITS People and we are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.