



# EMPLOYEE STATEMENT OF HEALTH

## Large Group – 51+

10421 South Jordan Gateway  
Suite 400  
South Jordan, Utah 84095

**Important:** Please complete this statement for all family members, whether or not they are enrolling for medical coverage.

**IMPORTANT: Please type or print all sections in ink.**

Name	Height: Feet/Inches	Current Weight	Weight 1 year ago
Employee:			
Spouse:			

The information on this form is used for underwriting purposes and may not be used to deny coverage to the individuals applying for coverage within the group.

**MEDICAL QUESTIONS** - If any question is answered "YES," please give details in space provided below.

<p>1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?</p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes (check below)</p> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Cardiac Disorder</td> <td><input type="checkbox"/> AIDS/Immune System Disorder</td> </tr> <tr> <td><input type="checkbox"/> Cancer (any form)</td> <td><input type="checkbox"/> Alcohol/Drug Abuse</td> </tr> <tr> <td><input type="checkbox"/> Diabetes</td> <td><input type="checkbox"/> Psychological Disorder</td> </tr> <tr> <td><input type="checkbox"/> Kidney Disorder</td> <td><input type="checkbox"/> Neuromuscular Disorder</td> </tr> <tr> <td><input type="checkbox"/> Respiratory Disorder</td> <td><input type="checkbox"/> Transplant Candidate</td> </tr> <tr> <td><input type="checkbox"/> Liver Disorder</td> <td><input type="checkbox"/> Stomach/Gastrointestinal Disorder</td> </tr> </table> <p>2. Have you or any of your dependent(s) had any medical conditions or treatment in the past 24 months requiring medical care or hospitalization in the amount of \$5,000 or more? <i>If so, for what condition(s)?</i></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes (note below)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> Cardiac Disorder	<input type="checkbox"/> AIDS/Immune System Disorder	<input type="checkbox"/> Cancer (any form)	<input type="checkbox"/> Alcohol/Drug Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Psychological Disorder	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Neuromuscular Disorder	<input type="checkbox"/> Respiratory Disorder	<input type="checkbox"/> Transplant Candidate	<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Stomach/Gastrointestinal Disorder	<p>3. Are you or any of your dependent(s) anticipating hospitalization or surgery, or have you or any of your dependent(s) had hospitalization or surgery recommended that has not been performed? <i>If so, for what condition(s)?</i></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes (note below)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>4. Are you or any of your dependent(s) currently pregnant or suspect you/they may be pregnant? <i>If yes, due date.</i></p> <p><input type="checkbox"/> No    <input type="checkbox"/> Yes (note below)</p> <p>_____</p> <p>_____</p> <p>_____</p>
<input type="checkbox"/> Cardiac Disorder	<input type="checkbox"/> AIDS/Immune System Disorder												
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<input type="checkbox"/> Liver Disorder	<input type="checkbox"/> Stomach/Gastrointestinal Disorder												

**DETAILS** — Attach additional sheets if necessary.

Question #	Family Member	Disease/Diagnosis/Treatment	Onset		Duration	Remaining Symptoms or Problems
			Mo.	Yr.		

**MEDICATIONS** — Please list any medications, prescriptions, or injections taken in the last 12 months. Attach additional sheets if necessary.

Family Member	Medication/Prescription/Injection	Dosage	Medical Condition

I, the Undersigned, hereby:

1. Declare that the foregoing answers, to the best of my knowledge and belief, are true and complete.
2. Authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, or any other organization, institution or person who has any record or knowledge of me or my spouse, or dependents to give such record or information to Altius. The authorizations shall be valid for 24 months from the date shown below. However, I may withdraw my consent for release of information at any time in the future. A reproduced copy of this authorization shall be as valid as the original.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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