

Small Employer Employee Statement of Health

PacifiCare®
of Oklahoma, Inc.

PacifiCare®
Life Assurance Company

IMPORTANT: PLEASE PRINT OR TYPE ALL SECTIONS IN BLACK INK.

Employer _____

Group # _____

This Statement is For: Employee Spouse* Child* (*complete only if dependent coverage is requested)

Type of Request: New Enrollment Add Dependent Coverage Late Enrollment Other

	Name	Date of Birth	Sex	Height - Feet/Inches	Weight
Employee					
Spouse					
Child					
Child					

If more dependents are enrolling, attach a separate sheet of paper, sign and date all additional papers.

THE MEDICAL INFORMATION COMPLETED ON THIS FORM MAY NOT BE USED TO DENY COVERAGE TO THE INDIVIDUALS APPLYING FOR COVERAGE, NOR IS IT MATERIAL TO THE ACCEPTANCE OF THE SMALL EMPLOYER'S APPLICATION FOR GROUP COVERAGE.

INSTRUCTIONS: Answer questions 1 through 6 with respect to the employee and dependents (if to be covered).

NOTE: If answer to any question is "YES", give details in space provided below. If more space is required, provide additional details on a separate sheet of paper. Please sign and date all additional papers.

	YES	NO
1. Have you or a dependent ever been diagnosed or treated by a member of the medical profession for any of the following:		
1a. Disease or disorder of eyes, ears, nose or throat?		
1b. Dizziness, fainting, convulsions, paralysis or stroke; mental disease or disorder; neurological disease or disorder; or substance/alcohol abuse or addiction?		
1c. Ulcer, hernia, colitis, intestinal bleeding; jaundice, or other disease or disorder of the stomach, intestines, liver or gall bladder?		
1d. Sugar, protein, blood in urine; stone or other disease or disorder of kidney, bladder, prostate or reproductive organs?		
1e. Neuritis, arthritis, or disease or disorder of the muscles or bones, including the back or joints?		
1f. Deformity or amputation?		
1g. Anemia, other blood or lymph disease disorder?		
1h. Disorder of menstruation, pregnancy, female organs or breasts?		

	YES	NO
If question 1i, 1j, 1k are answered "YES", please complete the Supplementary Medical Information on the reverse of this form.		
1i. Shortness of breath, bronchitis or other chronic respiratory disease?		
1j. Chest pain, palpitation, high blood pressure, heart murmur, heart attack or other heart/valvular/blood vessel disease or disorder of blood vessels?		
1k. Diabetes: cyst, tumor or cancer; thyroid or glandular disorder; skin disease or disorder?		
2. Disorder of the immune system, acquired immune deficiency syndrome (AIDS), or related syndrome?		
3. Are you or a dependent now under observation or treatment by a physician, psychiatrist or other practitioner?		
4. Are you or your dependent(s) currently pregnant?		
5. Other than as stated in answers to questions 1, 2, 3, 4, have you or your dependent(s) within the past 5 years:		
5a. Been attended by a physician/practitioner for consultation, examination, diagnosis or treatment?		
5b. Had any illness, or injury?		
5c. Had any surgery?		
5d. Been a patient in a hospital, clinic, sanitarium or other medical facility?		
5e. Had electrocardiogram, X-ray, or other diagnostic test?		
5f. Been advised to have any diagnostic test, hospitalization, treatment or surgery which was not completed?		
6. Have you or your dependents ever been advised of an elevated cholesterol problem?		

Question Number	Covered Person Employee, Spouse or Child	Disease/Diagnosis	Onset		Duration	Treatment and Result (Mention any surgery performed)
			Mo.	Yr.		

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 that has any record or knowledge of me or my spouse, to give such record of information to PacifiCare as permitted by law. The authorizations shall be valid for 24 months from the date shown below. However, you may withdraw your 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 _____

CM-304-61587.5

OKHEALTHSTFORM-01

PCPRE0301-11

POK7022

Supplementary Medical Information

PacifiCare[®]
of Oklahoma, Inc.

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Life Assurance Company

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Answer the following only if questions 1i, 1j, 1k on the reverse side of this form were answered with a "YES"

Employee Name: _____

Insured Person: _____ Employer: _____

1. Diagnosis or Symptoms: _____

2. Underlying Cause: _____

3. Age and date diagnosed: _____

4. Date first treated: _____

5. Are you currently taking any medication? If yes, provide medication name and daily dosage. _____

6. Was any surgery performed? If yes, provide date and type of surgery. _____

7. Is there any history of hospitalization or emergency room treatment? If yes, dates and reason for confinement/visit. _____

8. Are there any complications or residual problems? If so, please describe. _____

9. List your last blood pressure reading and the date it was recorded. _____

10. List all physicians seen within the last 2 years including dates and reason for consultation. _____

Diabetic Applicants: If question 1k on the reverse was answered with a "YES" answer the following questions in addition to 1-10 above.

11. Is there any history of high blood sugar or low blood sugar problems? If yes, please describe including date of occurrence, treatment and present condition. _____

12. Is there any history of eye, kidney, cardiovascular, circulatory or skin disorders? If so, please describe including date of occurrence, treatment and present condition. _____

Cardiac/Circulatory/Elevated Blood Pressure Applicants: If question 1j on the reverse was answered with a "YES" answer the following questions in addition to 1-10 above.

13. Do you have a history of chest pain? If yes, provide date of occurrence, treatment and present condition. _____

14. Have you ever had a heart attack? If yes, provide date of attack, dates of hospitalization, was any surgery performed? _____

15. List the date and results of your last EKG. _____

Emphysema/Chronic Obstructive Pulmonary Disease Applicants: If question 1i on the reverse was answered with a "YES" answer the following questions in addition to 1-10 above.

16. Do you have a history of or currently smoke cigarettes or use tobacco? If yes, how many packs daily? _____

17. List the date and results of your last chest X-ray. _____

Employee Signature _____ Date ____ / ____ / ____