Short Form Health Statement

Employee last name	First name	M.I.	Social Security no.

Employer/group name

1. Are you or your dependent(s) currently disabled or pregnant? . . . . . ☐ Yes ☐ No
2. In the past 24 months have you or your dependent(s) been hospitalized? . . . . . ☐ Yes ☐ No
3. Are your or your dependent(s) planning hospitalization? . . . . . ☐ Yes ☐ No
4. Have you or any dependent listed on the application had consultation for, received treatment or been advised to have treatment within the last five years for any of the following conditions, diseases or disorders? (Please respond to all questions).

AIDS or other immune system disorder (HIV, AIDS Related Complex, etc.)	☐ Yes ☐ No	Heart or vascular disease or stroke.	☐ Yes ☐ No
Alcohol or drug abuse	☐ Yes ☐ No	Kidney disorder/renal failure	☐ Yes ☐ No
Back, spine or bone diseases or arthritis. .	☐ Yes ☐ No	Lung disorder or emphysema	☐ Yes ☐ No
Blood disorder.	☐ Yes ☐ No	Multiple sclerosis.	☐ Yes ☐ No
Cancer or malignant conditions	☐ Yes ☐ No	Nervous/mental disorder	☐ Yes ☐ No
Cirrhosis, hepatitis or liver disorders	☐ Yes ☐ No	Organ transplant (history of or pending) . .	☐ Yes ☐ No
Diabetes or other endocrine disorders . . .	☐ Yes ☐ No	Parkinson's disease	☐ Yes ☐ No
Digestive or stomach disorder	☐ Yes ☐ No	Systemic disorder including lupus	☐ Yes ☐ No

Provide information for any "Yes" answer checked above. Include name of family member, nature of illness, dates and duration of treatment. If more space is needed, you may attach additional sheets.

Family member name	Name of condition/illness	Date(s) of service (MM/DD/YY)	Treatment received and current status	Prescription drugs – Include medication name and quantity taken per day
		From: To:		
		From: To:		
		From: To:		
		From: To:		
		From: To:		

Signature required

It is understood and agreed that the above answers are true and complete to the best of my knowledge and belief. I realize that any misrepresentation or omission regarding the presence of pre-existing conditions or disease may impact my rates or my coverage.

Employee signature **X**	Date (MM/DD/YY)

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