TakeCare®

Statement of Health

A. Instructions:

- Please print or type all sections in black ink.
- Answer every question in full or this form will be returned to you, resulting in a delay in processing of your coverage.
- Complete medical information for the last five (5) years for all persons listed on this form. Attach an additional sheet, if necessary. All additional pages should be signed and dated.
- I understand that upon becoming a member, any false statements or omissions may result in future claims being denied or termination of my coverage and possibly further legal action.
- The information completed on this form may not be used to deny coverage to the individuals applying for coverage.

B. Employer Information:

Employer:

This Statement is for: ☐ Employee ☐ Spouse ☐ Child

C. Employer & Dependent(s) Information:

	Name	Date of Birth	Sex	Height	Weight	Place of Birth
Employee			M F			
Spouse			M F			
Child			M F			
Child			M F			

If more dependents are enrolling, attach a separate sheet of paper, **sign, & date additional pages.**

D. Medical Information

Have you or your dependent ever been treated for or ever had any known indications of (**mark appropriate answer**):

1. Disease or disorder of eyes, ears, nose, or throat?	YES ☐	NO ☐
2. Dizziness, fainting, convulsions, paralysis or stroke?	YES ☐	NO ☐
3. Mental or nervous disease or disorder?	YES ☐	NO ☐
4. Shortness of breath; blood spitting; bronchitis or other chronic respiratory disease or disorder?	YES ☐	NO ☐
5. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disease or disorder of the heart of blood vessel?	YES ☐	NO ☐
6. Ulcer, hernia, colitis, intestinal bleeding, jaundice, hemorrhoids, or other disease or disorder of the stomach, intestines, liver or gall bladder?	YES ☐	NO ☐
7. Sugar, albumin, blood or pus in urine, stone or other disease or disorder of bladder, prostate or reproductive organs?	YES ☐	NO ☐
8. Disorder of kidney or kidney disease?	YES ☐	NO ☐
9. Cancer, cyst or tumor? Ever undergone chemotherapy or radiation treatment?	YES ☐	NO ☐
10. Diabetes, thyroid or glandular disorder, skin disease or disorder?	YES ☐	NO ☐
11. Neuritis, arthritis, gout, or disease or disorder of the muscles or bones including the back or joints?	YES ☐	NO ☐
12. Deformity, congenital anomaly or amputation?	YES ☐	NO ☐
13. Allergies, anemia, other blood or lymph disease or disorder?	YES ☐	NO ☐
14. Disorder of menstruation, infertility, pregnancy, multiple or premature births, female organs or breasts?	YES ☐	NO ☐
15. Treated or diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or any immune system deficiency (except HIV)?	YES ☐	NO ☐
16. Under ongoing observation or treatment by a physician or practitioner?	YES ☐	NO ☐
17. Ever been evaluated or considered for any type of transplant?	YES ☐	NO ☐
18. Been attended by a physician/practitioner for consultation, examination, diagnosis, or treatment?	YES ☐	NO ☐
19. Had any illness, injury, or surgery?	YES ☐	NO ☐
20. Been a patient in a hospital, clinic, or other medical facility?	YES ☐	NO ☐
21. Had electrocardiogram, x-ray, or other diagnostic test?	YES ☐	NO ☐
22. Been advised to have any diagnostic test, hospitalization, treatment or surgery which is not completed?	YES ☐	NO ☐
23. Ever been addicted to alcohol, drugs or any other substance?	YES ☐	NO ☐
24. Ever been advised or an elevated cholesterol problem?	YES ☐	NO ☐
25. Are you or a dependent currently pregnant?	YES ☐	NO ☐
26. Currently take prescription drugs for a condition not mentioned above?	YES ☐	NO ☐

E. Further Details:

Please provide us with FULL DETAILS for each item answered "YES" on the Medical Information section of this questionnaire. Include the last doctor visit and/or physical examination for all persons listed on this Statement of Health regardless of the date or reason. In addition, indicate any medication taken currently or within the last year. (Attach additional sheets if necessary.) **All sheets must be signed and dated**.

Question No.	FAMILY MEMBER NAME	NAME OF DOCTOR, HOSPTIAL, OR CLINIC

NAME OF CONDITION(S) OR ILLNESS(ES) TREATED	Date Treatment Began Month/Year	Still under treatment? DATE ENDED

INDICATE TREATMENT SUCH AS CHECK-UP, X-RAY, LAB AND SURGICAL PROCEDURE, ETC.

LIST NAMES OF MEDICATIONS PRESCRIBED, DOSAGE (AMT/FREQUENCY), DATE PRESCRIBED, DATE DISCONTINUED.

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LIST NAMES OF MEDICATIONS PRESCRIBED, DOSAGE (AMT/FREQUENCY), DATE PRESCRIBED, DATE DISCONTINUED.

Name:______________________________ Date:____________________

Signature:______________________________

F. Authorization:

1. I certify that the answers on this Statement of Health are true and complete. I understand that neither I nor my dependents will be eligible for benefits if any information is false or incomplete, that coverage may be revoked based on such a finding and that further legal action may be warranted.
2. Authorization for Disclosure of Personal Information (All Applicants):

   I hereby authorize any health care entity, physician or surgeon, or other health care professional to disclose or voluntarily provide to TakeCare Insurance Company, Inc, its agents or employees all information and medical records pertaining to any examination or treatment for any illness, injury or medical and related conditions, including treatment for substance abuse and mental or emotional disorders, furnished to or concerning me or my dependents who are applying for coverage. I understand all of this information is collected for evaluation and processing for coverage. I understand, however, that TakeCare Insurance Company, Inc. is under no obligation to request or review any of this information or records. This authorization is valid for thirty (30) days from the date inserted below unless revoked by me. A photocopy of this authorization is as valid as the original. I understand that I am, or my authorized representative is, entitled to receive a copy of this Authorization and Statement of Health.

I acknowledge that I have read & understand this form in its entirety.

Signature of Subscriber	Date
Signature of Spouse	Date
Signature of Dependents over 17 years of age	Date