CALIFORNIA

PacifiCare®

Small Business Individual Health Statement Application

Source Code	Tracking #

■ Type or Print in Black Ink ■ Please submit in a sealed envelope along with your completed Employee Enrollment Form

Employer Name

	First Name	Middle	Last	SS #	Date of Birth Mo - Day - Yr	Height	Weight	Sex
Employee								
Spouse								
Child								
Child								
Child								
Child								

	Yes	No
1. Are all named eligible persons listed above now in good health, free from any physical defect, injury or disease, and not under medical care? If "No," please give details on reverse side of this application..	☐	☐
2. Have you or any of the above persons ever had or been treated for any of the following? If "Yes," please give details:		
a. Disease or disorder of heart, kidneys, digestive system, liver, lungs, back, bones or joints?	☐	☐
b. High blood pressure, chest pain, rheumatic fever, alcoholism, drugs, diabetes or tuberculosis?	☐	☐
c. Schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, autism and other pervasive developmental disorders, anorexia, bulimia nervosa or any other nervous or mental conditions?	☐	☐
d. Cancer, tumor, goiter or arthritis?	☐	☐
e. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or any other immune system deficiency (except HIV)?	☐	☐
3. Within the past three (3) years, has any person listed above had any symptoms of, or received medical or surgical advice or treatment for, any serious or chronic condition other than mentioned above? If "Yes," please give details:	☐	☐
4. Does any applicant listed on this application currently take prescription drugs? If "Yes," list applicant's name(s), drug name(s), dosage and date started:	☐	☐

Name	Drug	Dosage/Date Started
Name	Drug	Dosage/Date Started
Name	Drug	Dosage/Date Started

5. Are you or any of the eligible persons pregnant? Provide details below.	☐	☐
6. Are you currently on continuation coverage from a former employer?	☐	☐

If "Yes": ☐ Federal COBRA ☐ Cal-COBRA

Detailed Answers to Health Statement Application and Medical Questionnaire

1. Pregnant eligible persons and expected due dates: _____
2. Details of medical questions. Provide full details. Attach a separate page if necessary. _____

Eligible Person	Nature of Illness/Injury	Mo/Yr	Duration	Recovered?	Explanation/Comments
				☐ Y ☐ N	
				☐ Y ☐ N	
				☐ Y ☐ N	

Authorization

I agree: All information on this form is correct and true. I further authorize my employer to deduct from my earnings any contribution required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment at least 30 hours per week.

Authorization to obtain or release medical information: I authorize any insurance company, health care service plan, health maintenance organization ("HMO"), physician, hospital, clinic, health care provider or other organization, institution or person having records or knowledge of anyone listed on this form to give **PacifiCare** or its designated agent any and all records pertaining to any medical history, including drug and/or alcohol abuse treatment or prevention, services or treatment provided to anyone listed on this application for purposes of review, investigation or evaluation. This authorization becomes effective immediately and shall remain in effect as long as necessary to process claims. A photocopy of this authorization is as valid as the original.

On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

Employee Signature	Date

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AND INSURANCE COMPANIES AS A CONDITION OF OBTAINING COVERAGE.

CM-903-52719
PC7302-004 Rev. 9/03