Virginia Group Health Insurance Medical History Form

Section 1: To Be Completed by Employer

EMPLOYER GROUP NAME	REQUESTED EFFECTIVE DATE

Section 2: Employee Information

Employee Name: _____ SSN: _____
Employee Address: (street, city, state & zip) _____
Name of Current Insurer/HMO: _____
Spouse Name: _____ SSN: _____
Spouse Address: (street, city, state & zip) _____
Name of Current Insurer/HMO: _____

INDICATE THE TYPE OF COVERAGE FOR WHICH YOU ARE APPLYING: ☐ Employee Only ☐ Employee and Spouse
☐ Employee and One Child ☐ Employee and Children ☐ Employee and Family

Section 3: Waiver of Coverage

Only complete this section if you wish to decline coverage for yourself, your spouse, other adult and/or your dependents.

I WISH TO DECLINE COVERAGE FOR:
☐ Myself ☐ My Spouse ☐ Other Adult ☐ My Dependents ☐ Myself and All Dependents

I WISH TO DECLINE COVERAGE FOR THE FOLLOWING REASON:

☐ Covered under other group coverage.

Name of Insurer/HMO: _____
Name of Insured: _____

☐ Covered by Medicare ☐ Covered by TRICARE or CHAMPVA
☐ Other (including individual coverage) _____
(provide details)

My employer has given me an opportunity to apply for group health coverage for myself and my dependents (if applicable). I have declined to apply for coverage as indicated above. I understand that by waiving coverage at this time, certain restrictions may apply to my ability to participate in this group insurance program at a later date.

Signature: **Date:**

Section 4: Medical History

Please provide the following information about each person to be covered by this policy. If you require more space than is provided, attach additional papers. If child(ren) do not reside at the same address as the employee, please provide the child(ren)'s address.

	First Name & Middle Initial	Last Name (if different from applicant)	Gender M/F	Date of Birth mm/dd/yyyy	Height	Weight	Step Child Y/N	Court-Ordered Coverage Y/N
Employee								
Spouse								
Child								

Address if different from employee: (street, city, state & zip)

Employee Name:_____

Section 4: Medical History (con't.)								
	First Name & Middle Initial	Last Name (if different from applicant)	Gender M/F	Date of Birth mm/dd/yyyy	Height	Weight	Step Child Y/N	Court-Ordered Coverage Y/N
Child								
Address if different from employee: (street, city, state & zip)								
Child								
Address if different from employee: (street, city, state & zip)								
Child								
Address if different from employee: (street, city, state & zip)								
Child								
Address if different from employee: (street, city, state & zip)								
Child								
Address if different from employee: (street, city, state & zip)								
If you or your spouse are a custodial parent to any dependent listed above, indicate who:								

Within the past five (5) years, have you or any other person listed on this form consulted or sought treatment, had treatment recommended, received treatment or therapy, been surgically treated, had surgery recommended, been hospitalized or taken any medication for any of the following conditions?

When answering questions on this medical history form, the information provided for each individual should include only information about that individual and should not include any genetic information. Genetic information includes family medical history and information related to the individual's genetic counseling or genetic diseases for which the individual may be at risk. All responses pertaining to an individual will only be considered and applied to the individual in question.

Yes	No	Condition
		1. AIDS (Acquired Immune Deficiency Syndrome) or HIV (Human Immunodeficiency Virus)
		2. Alcohol abuse, substance abuse, and/or use of illicit drugs
		3. Allergies
		4. Aneurysm
		5. Arthritis, rheumatism or other condition affecting one or more joints
		6. Asthma or other lung or respiratory disorder disease, emphysema, COPD, cystic fibrosis, sarcodosis, tuberculosis
		7. Back disorders, including disorders of the spine and intervertebral discs, and disc herniation/bulge
		8. Blood clots, peripheral vascular disease or other circulatory or vascular disorder
		9. Cancer or any tumor or growth
		10. Diabetes - If yes, what type?
		11. Elevated Cholesterol

Employee Name:_____

Section 4: Medical History (con't.)		
Yes	**No**	**Condition**
		12. Emotional or mental disorders, including, but not limited to, depression, manic depression, bi-polar disorder or Attention Deficit Hyperactivity Disorder
		13. Fibroidcystic breast or other breast disorders
		14. Fractures/Limb loss
		15. Gall stones or any other gallbladder disorder
		16. Gout
		17. Head, spinal cord injuries
		18. Heart or cardiovascular disorders, including, but not limited to, heart attack, heart murmur, irregular heart rate, valve disorders, angina or chest pain
		19. Hemophilia, anemia, sickle cell anemia, or other blood disorder
		20. Hepatitis – If yes, what type?
		21. Hypertension (high blood pressure)
		22. Intestinal disorders, including, but not limited to, diverticulitis, hernia, rectal disorders, colitis or Crohn's Disease
		23. Kidney disorders, including, but not limited to, kidney failure, kidney stones, bladder or genitourinary diseases or disorders, polycystic kidney disease, renal failure or on dialysis
		24. Liver disorders, including, but not limited to, cirrhosis
		25. Lupus, scleroderma, fibromyalgia, vasculitis, or any other connective tissue disorders
		26. Nervous system disorders, including, but not limited to, epilepsy, seizures, paralysis, multiple sclerosis, cerebral palsy, muscular dystrophy, Parkinson's Disease
		27. Prostate, testicular, erectile dysfunction
		28. Reproductive disorders: abnormal uterine bleeding, fibroids, menstrual disorders, endometriosis, infertility, other
		29. Sleep Apnea
		30. Stroke or TIA (mini stroke)
		31. Thyroid, goiter, glandular diseases or disorders, pituitary, pancreatic, or disorder requiring growth hormone
		32. Ulcers, acid reflux or other disorders of the stomach

33. If you checked yes to any conditions in Section 4, please provide full details on each medical condition below.

Question Number	Name of Person	Condition (include start date of condition)	Types of Treatment (Month/Year)	List Medications by name, dosage and give route (oral, injectable, infusion, or inhaled)	Is Ongoing Treatment Needed? If Yes, Please Explain:	Physicians Name

Employee Name:_____

Section 4: Medical History (con't.)						
Question Number	**Name of Person**	**Condition (include start date of condition)**	**Types of Treatment (Month/Year)**	**List Medications by name, dosage, and give route (oral, injectable, infusion, or inhaled)**	**Is Ongoing Treatment Needed? If Yes, Please Explain:**	**Physicians Name**

34. List any prescribed medications not otherwise identified in Section 4, number 33 (including fertility drugs) that you, your spouse, or any of your dependents listed on this form are currently taking. Use additional papers if needed.

Name of Person	List Medications by name, dosage, and give route (oral, injectable, infusion, or inhaled)	For what condition?

Employee Name:_____

Section 5: Additional Information

1. Has anyone named in this application used tobacco products within the past 12 months? If yes, explain:

2. Within the past five (5) years, have you or any other person listed on this form, consulted or sought treatment, had treatment recommended, received treatment or therapy, been surgically treated, had surgery recommended, hospitalized for, or taken medication for any medical condition or disorder not mentioned above? If yes, explain:

3. Are you or anyone listed on this form currently pregnant? If yes, Due Date:
If you checked yes, please explain:

4. Any future surgeries or treatment discussed, planned or recommended in the next 12 months? If yes, explain:

Section 6: Certification and Enrollment

In connection with this application for coverage with the insurer(s)/HMO(s) identified below, I certify that I have read, or have had read to me, this completed form, and I realize that any act or practice that constitutes fraud or intentional material misrepresentation of fact in this form may result in loss or rescission of coverage. I acknowledge that all claims relating to such fraudulent act, practice or intentional material misrepresentations of fact will become my responsibility if incurred after termination or as a result of rescission.

I understand and agree that the insurer(s)/HMO(s) identified below will rely upon the above information and answers as the basis for establishing group premium rates for health care coverage.

I authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurer(s)/HMO(s) or other organization, institution or person that has any knowledge of my health or the health of my spouse and/or dependents as listed on this form to disclose such information to the extent permitted by law to the insurer(s)/HMO(s) identified below for the purpose of compiling an accurate evaluation of this form and to establish group premium rates for the group. This authorization does not permit the use or disclosure of psychotherapy notes. Authorization to disclose information for the payment of claims is valid for the term of coverage and in connection with application for coverage, policy reinstatement or a request for change in policy benefits, this authorization shall be valid for thirty (30) months from the date shown below.

I understand that I may be contacted by the insurer(s)/HMO(s) identified below to obtain additional follow-up information on health conditions disclosed in Section 4 and 5 of this document for me, my spouse and/or my covered dependents.

I understand that I or my authorized representative may receive a copy of this authorization upon request. I agree that a photographic copy of this authorization shall be as valid as the original.

Full and proper corporate name of Insurer(s)/HMO(s)

Employee Signature: **Daytime Tel. No.** **Date**:

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