Personal Health Statement

(Only necessary if claim utilization reports are not available from current carrier)

EMPLOYER______________________________

NAME OF EMPLOYEE and GENDER or GENDER ______________________________
NAME OF DEPENDENT and GENDER or GENDER ______________________________
NAME OF DEPENDENT and GENDER or GENDER ______________________________
NAME OF DEPENDENT and GENDER or GENDER ______________________________

HEALTH INFORMATION **APPLICANT MUST ANSWER EVERY QUESTION**

EMPLOYEE Date of Birth ____________________
Weight ____________________
Your Height __________ft. __________ in.

EMPLOYEE'S SPOUSE *(if coverage to include spouse)* Date of Birth ____________________
Weight ____________________
Height __________ft. __________ in.

CHILDREN Name:____________________ DOB:__________
Name:____________________ DOB:__________
Name:____________________ DOB:__________
Name:____________________ DOB:__________

Have you or any other person listed on the application in the past ten (10) years had a diagnosis of, advice for, indication of, symptoms related to, treatment for, or accident or injury related to any of the following systems, diagnoses, disorders, diseases, conditions or symptoms?

	Yes	No	
A.	☐	☐	Heart or circulatory system, including high blood pressure, Heart attack, chest pain, heart murmur, irregular heartbeat, varicose veins, phlebitis or poor circulation.
B.	☐	☐	Lung or respiratory system, including shortness of breath, Asthma, hay fever or other allergies, chronic cough, tuberculosis, emphysema or pneumonia
C.	☐	☐	Genito-Urinary system, including kidney stones, cystitis, Prostate, bladder infection, breast, uterus, venereal disease, C-section, complications of pregnancy, abnormal pap smear, Or menstrual disorder.
D.	☐	☐	Digestive system, including ulcer, gallbladder, gastritis Intestinal problem, colitis, hemorrhoids, hernia, pancreas, liver Or spleen
E.	☐	☐	Muscular or skeletal system, including back, joints, bones, muscles, spine, gout, arthritis or rheumatism
F.	☐	☐	The nervous system, including severe headaches, paralysis, seizures, convulsions, epilepsy, nervousness, fainting, dizziness, mental, or emotional disorders or psychiatric care
G.	☐	☐	Eye, ear, throat mouth or teeth
H.	☐	☐	Any type of cancer, tumor, cyst or other growth, skin problem, goiter, thyroid, anemia, hemophilia or other glands, blood and blood forming organs
I.	☐	☐	Diabetes, elevated blood sugar; or blood sugar, or albumin in the urine
J.	☐	☐	Alcohol or drug dependency, overdose reaction, abuse, or counseling by Alcoholics Anonymous or similar organization.
K.	☐	☐	Acquired immune deficiency syndrome (AIDS)
L.	☐	☐	Sudden weight loss, night sweats, persistent fever, Malaise mouth infection or lymph node enlargement
M.	☐	☐	Any other abnormality, deformity, developmental defect, abnormality, disease or disorder

NOTE: If you have answered Yes to any questions in this block, please indicate the question letter(s), Person's name, doctor's name and address, treatment, dates, results. Medications and any other pertinent information in the space below.

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N. Is any individual to be enrolled pregnant? ☐ Yes ☐ No

O. Have you or any individual listed on this application seen a doctor, had surgery, been hospitalized, institutionalized, or had an accident requiring medical treatment? ☐ Yes ☐ No If yes, please explain:______________________________

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CONTINUED ON BACK

P. Does any individual to be enrolled take prescription drugs? ☐ Yes ☐ No If yes, list drug(s) below:

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Q. Do you or any person listed on the application have symptoms of, or trouble with, any physical, mental or emotional condition for which such person has not yet seen a doctor or for which treatment has been recommended? ☐ Yes ☐ No If yes, please explain:____

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R. List Doctor(s) name, address and phone number for each individual to be insured:

Individuals To be Covered	Doctor's Name	Doctor's Address	Doctor's Phone Number

S. Have you or any person listed ever been rejected for health coverage? ☐ Yes ☐ No If yes, please give a complete explanation:

____

T. Have you or any person listed been disabled or are currently disabled? ☐ Yes ☐ No
Date of Disability: _________________________

U. Have you or any person listed ever been considered as not actively at work? ☐ Yes ☐ No

I have________(number) children eligible as dependent in the group policy.

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form a part of my application form for healthcare benefits and that such benefits will not become effective until such application has been approved by TML MultiState Intergovernmental Employee Benefits Pool (TML MULTISTATE IEBP).

MEDICAL INFORMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical facility, health benefit organization, Medicare Part A and Part B carrier, or other organization, institution or person, that has any records or knowledge of me, my spouse and all dependent children proposed for coverage, or our health, to give TML MULTISTATE IEBP or its reinsurers any such information. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Exemptions from Privacy and Confidentiality include research, limited law enforcement activities, clinical and administrative proceedings, emergency circumstances, identification of a body of deceased person or cause of death, activities related to nation defense and security.

Except as noted below, we will not disclose information about you without your authorization. TML MULTISTATE IEBP may, without your prior consent and only as permitted by law to provide information to:

- Payment of services, including collections and subrogation
- Reinsurance Carrier
- TML MULTISTATE IEBP's Business Associates
- Eligibility Clearing House
- Professional Healthcare Negotiations
- Response to valid Summons, Court Orders, Search Warrant, Subpoenas
- Prescription Benefit Manager
- Any other entity for any other purpose allowed under 45 CFR Part 164

- ☐ I understand that any communication among the physician, patient, TML MultiState Intergovernmental Employee Benefits Pool and the Medical Management staff is confidential.
- ☐ I hereby authorize TML MultiState Intergovernmental Employee Benefits Pool to review medical records and discuss my medical condition and treatment with my physician and other health care providers.
- ☐ This consent remains in effect for as long as TML MultiState Intergovernmental Employee Benefits Pool requires the information in reviewing medical services and costs of medical services for this treatment episode, unless revoked in writing by the covered person. A photocopy of this consent is as valid as the original.

Signature of Employee or Covered Individual____ Date _________________________