



## Employee Health Application Form

### Section 1: Employer Information

Employer Name: \_\_\_\_\_ Hire Date: \_\_\_\_\_  
 Employer Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

### Section 2: Employee Information

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Last First M.I.  
 Address: \_\_\_\_\_  
 City State Zip Job Title  
 Marital Status:  Single  Divorced  Married  Widowed  
 Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone: ( \_\_\_\_\_ ) \_\_\_\_\_  
 E-mail Address: \_\_\_\_\_ Hours Worked per Week: \_\_\_\_\_  
 Spouse's Employer: \_\_\_\_\_ Spouse's Business Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

### Section 3: Other Insurance Coverage

Are you or any dependent(s) disabled  YES  NO If YES, please indicate name(s): \_\_\_\_\_  
 Do you or your spouse have other health insurance coverage that will continue in addition to this coverage?  YES  NO  
 If YES, name of Carrier: \_\_\_\_\_  
 Policy Holder's Name: \_\_\_\_\_ Policy #: \_\_\_\_\_ Effective Date: \_\_\_\_\_  
 Name of Covered Dependents: \_\_\_\_\_

### Section 4: Subscriber / Dependents (Please complete for employee subscriber and all participating dependents.)

First Name	Last Name	Relationship (Spouse, Son, Daughter)	Social Security #	DOB	Age	M / F	Tobacco Use YES / NO
		Employee					

### Section 5: Health Plan Participation

I elect to participate  
 I decline participation  
 If declining, provide reason below:

**Coverage Level** (Choose 1)  
 Employee Only  
 Employee / Spouse  
 Employee / Child(ren)  
 Family

**Plan Selected**  
 Options provided upon  
 underwriting approval

Reason for decline:

- Spouse's Employer's Plan  Individual Plan  Medicare  Medicaid  COBRA from Prior Employer  
 VA Eligibility  I (we) have no other coverage at this time  Other: \_\_\_\_\_

### Section 6: Health Information

Please furnish us with the height and weight for you and your spouse:

**Self:** Height \_\_\_\_\_ feet \_\_\_\_\_ inches; Weight \_\_\_\_\_ lbs **Spouse:** Height \_\_\_\_\_ feet \_\_\_\_\_ inches; Weight \_\_\_\_\_ lbs

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

- |                              |                              |                             |   |                              |                             |
|------------------------------|------------------------------|-----------------------------|---|------------------------------|-----------------------------|
| A. Cardiac Disorder          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | H. AIDS / HIV / Immune System Disorder            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Cancer / Tumor (any form) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | I. Alcohol / Drug Abuse                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Diabetes                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | J. Mental / Nervous Disorder                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Kidney Disorder           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | K. Neuromuscular Disorder                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Respiratory Disorder      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | L. Stomach / Gastrointestinal                     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Liver Disorder            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | M. Arthritis, Back, Bone, Joint Disorder          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. High Blood Pressure       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | N. Seizures, Convulsions, Epilepsy                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|                              |                              |                             | O. Any Other Medical Condition (not listed above) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

2. Within the past 5 years, have you or any dependent ever had an application for insurance declined, postponed, rated, or otherwise modified? .....  Yes  No

3. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, prescription management, surgery, hospitalization or had more than \$5,000 in medical expenses?.....  Yes  No

If Yes, please provide information on who and for what conditions in space provided below.

4. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? If Yes please provide information below.....  Yes  No

5. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant? If Yes, please provide due date and detail in space provided below. ....  Yes  No

If you answer "Yes" to any of the questions above, please provide detail in space provided below. (If needed, please attach additional sheets, signed and dated by the employee subscriber.)

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications - List any medications, prescriptions, or injections taken in the last 12 months. (Attach Additional Sheets as Necessary.)

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

**Agreements**

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

**Medical Authorization**

I authorize any of the following to disclose any data it has on me, my health or on the health of my family. (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) The Medical Information Bureau; (5) any other organization, institution, or person that has any data on me or my health or on the health of my family. A copy of this shall be as valid as the original.

**Fraud Warning**

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

**Section 7: Employee Signature**

I hereby authorize my healthcare providers to disclose information from my medical records to Medova Healthcare Financial Group and Medova's respective carriers to the extent necessary to for underwriting and benefit eligibility. In the event that I enroll in a Lifestyle Health Plan, I hereby agree to abide by the terms and conditions of all benefit plan summary documents, which contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_