

Health Statement



Blue Shield of California and Blue Shield of California Life & Health Insurance Company

(Applicable To All 2-14 Enrolling Employees and Non-Guaranteed Issue Groups Only)

If you would like to keep this statement confidential, please submit it in a sealed envelope along with your completed application.

Please complete the following health questionnaire. Your answers to the questions below do not affect your eligibility for coverage and will not be used as a basis of excluding coverage for any medical condition, with the exception of a pre-existing condition if applicable to the terms of your group health plan.

(Please print)

	Name	Social Security #	Height	Weight
Employee				
Dependent				
Dependent				
Dependent				

Please answer YES or NO to each of the following questions for yourself and each of your dependents. (If you answer YES to any of the questions below, please explain referencing the Q# in the section following question #20)

		Yes	No
1	Been admitted to a hospital or had surgery in the past five (5) years? (If yes, explain below)	<input type="checkbox"/>	<input type="checkbox"/>
2	Within the past two years, have you, or has any dependent you are enrolling, been disabled and/or incurred medical costs exceeding \$5,000.00? (If yes, explain below)	<input type="checkbox"/>	<input type="checkbox"/>
3	Been told that it may be necessary for you to be admitted to the hospital or have surgery in the future? (If yes, explain below)	<input type="checkbox"/>	<input type="checkbox"/>
Been diagnosed with, treated for or had treatment for any of the following: (If yes, explain below)			
4	Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>
5	Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>
6	Cancer, tumor or other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>
7	Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>
8	Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>
9	AIDS, AIDS-related complex or other immune deficiency disorders (except HIV infection), infections or chronic infection problems?	<input type="checkbox"/>	<input type="checkbox"/>
10	Alcohol or substance abuse, mental/nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>
11	Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?	<input type="checkbox"/>	<input type="checkbox"/>
12	Diabetes, cystic fibrosis albumin or sugar in the urine or other endocrine problems?	<input type="checkbox"/>	<input type="checkbox"/>
13	Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?	<input type="checkbox"/>	<input type="checkbox"/>
14	Paralysis, epilepsy, multiple sclerosis or other neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
15	Bleeding or blood disorders, (except for HIV infection)?	<input type="checkbox"/>	<input type="checkbox"/>
Other Conditions/Information			
16	Are you or any dependents now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
17	Any other medical condition that has not been disclosed above? If so, describe in detail below?	<input type="checkbox"/>	<input type="checkbox"/>
18	Have you or your dependents smoked in the last two years? If Yes, date stopped: / /	<input type="checkbox"/>	<input type="checkbox"/>

(continued on page 2)

An Independent Member of the Blue Shield Association

