UnitedHealthcare®
A UnitedHealth Group Company

CALIFORNIA

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								

FOR ANY "YES" ANSWERS, PLEASE GIVE DETAILS IN THE SECTION PROVIDED BELOW

1. a. Is any female to be covered currently pregnant ? ☐ Yes ☐ No
   b. If you are a male listed on this application, are you expecting a child with anyone, even if the mother is not listed on the application? ☐ Yes ☐ No
   c. If yes to "a" or "b", is there current or a history of complications or multiple gestation birth? ☐ Yes ☐ No
2. In the last five years, have you or any eligible dependents incurred a claim in excess of $5,000? ☐ Yes ☐ No
3. Within the past five years, has any person to be insured been diagnosed or treated by a physician or member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
4. Is any person to be insured disabled, hospital confined, receiving treatment, taking medication, or been advised of a condition that will require attention or routine follow-up in the next 24 months? ☐ Yes ☐ No
5. Within the past five years, has any person to be insured been diagnosed, had symptoms, had testing completed, had treatment, taken medications or had routine follow up for any of the following: Cancer/Tumor, Diabetes, Heart/Blood/Vascular Disorder, Kidney Disorder, Liver Disorder, Neurological Disease, Respiratory-Lung Disorder, Stroke, Systemic Lupus/Multiple Sclerosis, Transplants, or Mental or Emotional Disorder? ☐ Yes ☐ No
6. Are you currently on continuation coverage from a former employer? ☐ Yes ☐ No
   If "Yes": ☐ Federal COBRA ☐ Cal-COBRA

For groups enrolling 2-10 employees or late enrollees, complete the following Additional Medical History Section below.

Within the past five years, has any person to be insured ever had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for…

A. Alcohol/Drug Abuse ☐ Yes ☐ No
B. Arthritis/Back/Joint Disorder ☐ Yes ☐ No
C. Asthma/Tobacco Usage ☐ Yes ☐ No
D. Blood Disorder ☐ Yes ☐ No
E. Breast Disorder or Breast Implants ☐ Yes ☐ No
F. Congenital Disorder or Deformity ☐ Yes ☐ No
G. Digestive/Eating Disorder ☐ Yes ☐ No
H. Ear/Eye Disorder ☐ Yes ☐ No
I. Epilepsy/Seizures ☐ Yes ☐ No
J. Genital/Urinary Disorder ☐ Yes ☐ No
K. High Blood Pressure ☐ Yes ☐ No
L. Infertility ☐ Yes ☐ No
M. Muscle Disorder/Neurological Disease ☐ Yes ☐ No
N. Skin Disease ☐ Yes ☐ No
O. Thyroid/Adrenal Disorder ☐ Yes ☐ No
P. Tuberculosis/Hepatitis A, B or C ☐ Yes ☐ No
Q. Sleep Apnea ☐ Yes ☐ No
R. Systemic Infection ☐ Yes ☐ No

Detailed Answers to Questions 1 – 5 and the Additional Medical History Section

1. Pregnant persons and expected due dates:____________________
2. Provide full details to all "Yes" answers noted above. Attach a separate page if necessary.

Eligible Person	Nature of Illness//Injury	Mo/Yr	Medication/ Treatment	Recovered? (Yes or No)	Explanation/Comments
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	
				☐ Yes ☐ No	

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 (or 20-29 hours per week if elected by my employer).

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.

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