Anthem Life

HEALTH STATEMENT

This health statement is part of the application for coverage and applies to the employee and all dependents. All parts must be completed and returned to us with the application. Statements with incomplete, inaccurate, or illegible information will be returned to you, causing a delay in the application.

Employer name (group) _____ Group number (if known) _____

Employee name _____ Social security number _____ Weight ____ Height _____

Spouse name _____ Birthdate _____ Social security number _____ Weight ____ Height _____

Dependent name _____ Birthdate _____ Weight ____ Height _____

Dependent name _____ Birthdate _____ Weight ____ Height _____

Dependent name _____ Birthdate _____ Weight ____ Height _____

Dependent name _____ Birthdate _____ Weight ____ Height _____

Dependent name _____ Birthdate _____ Weight ____ Height _____

Have you or your listed dependents consulted, had diagnostic or other medical tests, or been treated by any doctor, health care professional, or hospital emergency room or clinic within the last five (5) years for any of the following conditions or disorders?

	YES	NO	
(1)	☐	☐	AIDS (Acquired Immune Deficiency Syndrome), HIV, or ARCS (AIDS Related Complex Symptoms)
(2)	☐	☐	Alcohol or Drug Abuse
(3)	☐	☐	Asthma, Emphysema, Lung Diseases, or Bronchitis
(4)	☐	☐	Back Conditions, Bone or Spinal Diseases
(5)	☐	☐	Blood or Blood Element Disorders
(6)	☐	☐	Brain or Nervous System Disorders
(7)	☐	☐	Cancer or Other Malignant Conditions
(8)	☐	☐	Cardiovascular Disorders including Hypertension and Heart Disease
(9)	☐	☐	Diabetes or Other Endocrine (Glandular) Disorders
(10)	☐	☐	Digestive or Stomach Disorders
(11)	☐	☐	Ear Diseases or Disorders
(12)	☐	☐	Epilepsy, Convulsions, Seizures, Fainting, Paralysis
(13)	☐	☐	Eye Disorders, Cataracts
(14)	☐	☐	Gallbladder Disorders
(15)	☐	☐	Genital Disorders, Male/Female
(16)	☐	☐	Hemorrhoids
(17)	☐	☐	Hernias
(18)	☐	☐	High Blood Pressure: If yes, give last reading: _____ Date of last reading: _____
(19)	☐	☐	Hypoglycemia
(20)	☐	☐	Infertility or Sterility
(21)	☐	☐	Kidney, Bladder, or Urinary Conditions
(22)	☐	☐	Liver Conditions, including Cirrhosis or Hepatitis
(23)	☐	☐	Nervous and Mental Disorders including Anxiety, Depression, and Self-Inflicted Injuries
(24)	☐	☐	Pregnancy (If yes, give estimated delivery date _____)
(25)	☐	☐	Sinus, Tonsil, or Adenoid Disorders
(26)	☐	☐	Ulcers
(27)	☐	☐	Any other conditions not listed: _____

If any of the above boxes are checked "Yes," provide information for you (and your family members) as indicated below. This section must be completed. (If additional space is required, attach separate sheet.)

Applicant	Condition/Symptoms	Person or Facility Giving Treatment	Address Where Treatment Took Place	Treatment Dates	
				First	Last

1. Have you or your listed dependents had surgery or been hospitalized within the past 5 years? ☐ Yes ☐ No
   If yes, list the diagnosis, type of surgery, date of surgery, hospital's and physician's name and address, and the date(s) of hospitalization. Use a separate sheet if needed: _____
2. Have you or your listed dependents been advised to be hospitalized or to have an operation or diagnostic examination not yet performed? ☐ Yes ☐ No If yes, explain: _____
3. Have you or your listed dependents taken any prescription drugs for more than 30 days during the last year? ☐ Yes ☐ No
   If yes, list the medication, dosage, and name of prescribing physician (state condition for which drug is taken): _____
4. Has any company refused or restricted life, disability, or health insurance coverage for you or your listed dependent? ☐ Yes ☐ No
   If yes, specify company and restriction, and attach copy of rider: _____

I authorize any physician, hospital, or health care provider to furnish medical records and information for the applicant to Anthem Blue Cross and Blue Shield and/or Anthem Life Insurance Company. This authorization specifically gives Anthem Blue Cross and Blue Shield and/or Anthem Life Insurance Company the right to examine any medical records and information related to this application or for any claims incurred during the applicant's membership. I certify that all information entered is correct. If I have misstated or omitted any information, I realize that the contract can be considered null and void by Anthem Blue Cross and Blue Shield and/or Anthem Life Insurance Company. I understand that if this application is accepted, coverage may be subject to pre-existing condition limitations based on the coverage for which application is being made.

Signature of _____ Date _____

FOR INTERNAL USE ONLY
_____
_____ Initials
Date