



Health Statement Form

Groups of 2-50 employees

Relationship to employee

Group name: _____

	Name	Gender	DOB	Height	Weight
Self					
Spouse					
Child					
Child					
Child					

Employee phone number: Home () _____ - _____ Cell () _____ - _____ ZIP code: _____

- Is any person to be covered currently pregnant or an expectant parent? Yes No
 If yes, who? _____ Expected due date? ____/____/____
 Complications/high risk/multiple births? Yes No If yes, explain: _____
- Has any person to be covered had, been told he or she had, been advised to have treatment for, had follow-up visits for, or received treatment for:

Please check either yes or no for each item below.	YES	NO
A. Heart or circulatory system disorders including but not limited to: chest pain or angina, heart attack, heart surgery or bypass, heart murmur or valve disorder, stroke, aneurysm?		
B. High blood pressure? If yes, give last two readings: Systolic _____ Diastolic _____; Systolic _____ Diastolic _____		
C. Blood disorders including but not limited to: anemia, hemophilia, leukemia, excessive iron in the blood?		
D. Muscle, bone or joint disorders including but not limited to: joint replacement, chronic back pain, rheumatoid arthritis, fibromyalgia, osteoarthritis or spinal disorder?		
E. Nervous or mental disorders including but not limited to: depression, bi-polar disorder, eating disorders, cerebral palsy, paralysis, multiple sclerosis, seizures or Parkinson's disease?		
F. Stomach or intestinal disorders including but not limited to: ulcerative colitis, Crohn's disease, recurrent stomach ulcers?		
G. Disorders or pituitary, pancreas, liver or adrenal gland including but not limited to: Addison's disease, cirrhosis, diabetes, pituitary tumor, or all kinds of Hepatitis? If Diabetes, taking insulin? <input type="checkbox"/> Yes <input type="checkbox"/> No Meds? <input type="checkbox"/> Yes <input type="checkbox"/> No		
H. Lung or breathing disorders including but not limited to: asthma, emphysema, COPD?		
I. Kidney disorders including but not limited to: recurrent infections, recurrent stones, kidney cysts?		

Please check either yes or no for each item below. (Continued from page one.)	YES	NO
J. Female reproductive disorders including but not limited to: endometriosis, uterine fibroids, infertility, menstrual disorders, abnormal PAP smears or sexually transmitted disease?		
K. Male reproductive disorders including but not limited to: enlarged prostate, infertility, sexually transmitted disease?		
L. Immune disorders including but not limited to: AIDS, HIV positive, ARC (AIDS related complex) or enlarged lymph nodes?		

For every "Yes" answer above please complete the following:

Question	Name	Condition	Date of onset	Date of recovery	Current treatment

3. Has anyone to be covered been diagnosed with cancer or malignant tumor in the past 10 years? Yes No
 If yes, who: _____ Date treatment ended: ____/____/____
 Type of cancer: _____ Type of treatment: _____
4. Has anyone to be covered received treatment for alcohol or drug use in the past five years? Yes No
 If yes, who: _____ Was treatment for alcohol, drug use or both: _____
 Confined to a medical or drug rehabilitation facility? Yes No Date treatment ended: ____/____/____
5. Has anyone to be covered been advised or is waiting to have any test or operation performed? Yes No
 If yes, who: _____ Describe test or operation needed: _____
 Has it been scheduled? Yes No If yes, give date: ____/____/____
6. Has anyone to be covered incurred medical expenses in excess of \$10,000 in the past 12 months? Yes No
 If yes, who: _____ Please give reasons, dates and whether the person has recovered: _____

7. Does anyone to be covered have an ongoing medical condition not listed above? Yes No
 If yes, who: _____ Condition: _____
 Type of treatment: _____
8. Is anyone to be covered the recipient of, or on the waiting list for an organ (heart, kidney, lung) transplant? Yes No
 If yes, who: _____ Which organ: _____
 Date of transplant: ____/____/____ Current treatment: _____
9. Is anyone to be covered currently disabled or receiving disability benefits? Yes No
 If yes, who: _____ Type of disability: _____
 Date of onset: ____/____/____

10. Please list all prescription medications currently being taken by each person to be covered:

Person's name	Medication	Reason for use

By signing below, I attest that all the information completed on this form is true and complete and that all the persons listed are eligible for enrollment. I understand that ODS will only use this information as part of the group rate determination process. I further understand that if I have misstated or omitted any information on this form, ODS may reassess the rates charged to my employer or terminate coverage in accordance with the laws of the state of Alaska. I will promptly inform ODS in writing if anything happens before my coverage takes effect that makes this health statement incomplete or incorrect. I (We) authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or medically-related facility, the Medical Information Bureau (MIB) or other organization, institution or person that has knowledge or records of me (our) and my (our) health to use and disclose a copy of my protected health information to ODS Health Plan, Inc. for the purpose of enrollment determination or eligibility, claim payments and policy underwriting. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

I have the right to revoke this Authorization in writing at any time. If I revoke this Authorization, the information described above will no longer be used or disclosed for the reasons covered by this written Authorization. Any uses or disclosures already made with my permission cannot be taken back. Unless revoked, this Authorization shall be in force and effect for twenty-four (24) months from the date of the signature below. To revoke this Authorization, please send a written statement to ODS Health Plan, Inc., Privacy Office, 601 S.W. Second Avenue, Portland, OR 97204 and state that you are revoking this Authorization. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits. If you decide not to sign this authorization we may decline to enroll you in our health plan, provide benefits and payment for treatment.

I (We) have reviewed and I (we) understand this Authorization.

Employee signature: _____ Date: _____

Spouse signature: _____ Date: _____