

GROUP INSURANCE HEALTH STATEMENT



Group Marketing Services, Inc.

● P.O. Box 19040 - Kalamazoo, MI 49019

- Employee Life Only
- Employee Life and Health
- Dependent Life and/or Health

Any person who knowingly and with intent to defraud or deceive any insurance company, files a statement of claim containing any materially false, incomplete or misleading information is guilty of committing a fraudulent insurance act which is a crime and subject to criminal prosecution.

EMPLOYEE NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH (MM/DD/YY)	HEIGHT	WEIGHT	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
STREET ADDRESS				CITY	STATE	ZIP CODE	
SOCIAL SECURITY NUMBER		EMPLOYER		HIRE DATE (MM/DD/YY)		NUMBER OF HOURS WORKED PER WEEK	

EMPLOYMENT STATUS FULL TIME PART TIME SEASONAL CONTRACTED BOARD MEMBER

ARE YOU OR ANY DEPENDENT ELIGIBLE FOR MEDICARE BENEFITS? (YES OR NO)	NAME OF PERSON(S)
ARE YOU OR ANY DEPENDENT COVERED BY OTHER INSURANCE? (YES OR NO)	NAME OF INSURANCE COMPANY:
ARE YOU OR ANY DEPENDENT NOW DISABLED? (YES OR NO)	NAME OF PERSON(S)
ARE ANY DEPENDENTS LISTED NOT A LEGAL SPOUSE, BIOLOGICAL CHILD OR STEPCHILD? (YES OR NO)	NAME OF PERSON(S)

LIST NAME(S) OF ALL ELIGIBLE DEPENDENTS YOU WISH COVERED				DATE OF BIRTH (MM/DD/YY)	HEIGHT	WEIGHT	RELATIONSHIP
LAST	FIRST	MIDDLE					
A.							<input type="checkbox"/> SPOUSE DATE MARRIED <u> / / </u>
B.							<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
C.							<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
D.							<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER
E.							<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER

ANSWER EVERY QUESTION YES (Y) OR NO (N) FOR EMPLOYEE AND DEPENDENT, IDENTIFYING EACH DEPENDENT WITH A, B, C, ETC. PLEASE INDICATE YES or NO
EXPLAIN "YES" ANSWERS.

HAVE YOU OR ANY OF YOUR DEPENDENTS:	EMPLOYEE	DEPENDENT
1. HAD A WEIGHT CHANGE IN THE PAST YEAR.		
2. EVER HAD, BEEN ADVISED OF, OR SOUGHT TREATMENT FOR HIGH BLOOD PRESSURE, OR CHEST PAIN.		
3. EVER HAD BACK TROUBLE, CIRCULATORY DISORDER, PHLEBITIS, PARALYSIS, EPILEPSY, NERVOUS MENTAL DISORDERS, UNCONSCIOUSNESS, DIABETES, ANY DISORDER OF THE KIDNEYS, BLADDER, LIVER, PROSTATE, REPRODUCTIVE ORGANS, CANCER OR TUMOR.		
4. EVER HAD EMPHYSEMA OR TUBERCULOSIS, ASTHMA OR ANY DISORDER OF THE LUNGS.		
5. HAD MUSCULAR OR SYSTEMIC DISEASE SUCH AS ARTHRITIS OR LUPUS.		
6. EVER BEEN IN THE HOSPITAL, SANATORIUM OR OTHER INSTITUTION FOR TREATMENT, TESTING, OBSERVATION OR X-RAY IN PAST 2 YEARS.		
7. CONSULTED A PHYSICIAN, SURGEON, OR A HEALTH PRACTITIONER FOR ANY PURPOSE IN THE PAST 2 YEARS.		
8. BEEN COUNSELED OR TREATED FOR OR HAD TREATMENT RECOMMENDED FOR EXCESS USE OF ALCOHOL OR DRUGS.		
9. TAKEN PRESCRIPTION DRUGS OR INSULIN FOR MORE THAN 15 DAYS IN THE PAST 24 MONTHS.		
10. EVER HAD AN APPLICATION FOR INSURANCE DECLINED, POSTPONED OR MODIFIED IN ANY WAY.		
11. BEEN TOLD YOU HAVE AN IMMUNE SYSTEM DISORDER, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), AIDS RELATED COMPLEX (ARC), OR TEST RESULTS INDICATING EXPOSURE TO AN AIDS VIRUS.		
12. EVER HAD ANY ILLNESS, DISEASE, INJURY OR PHYSICAL IMPAIRMENT NOT MENTIONED ABOVE.		
13. ARE YOU OR ANY DEPENDENT TO BE COVERED NOW PREGNANT, HAD A CESAREAN SECTION, OR BEEN ADVISED IN THE PAST 12 MONTHS THAT HOSPITALIZATION, SURGERY OR TREATMENT IS NEEDED OR PENDING.		
14. EVER BEEN DIAGNOSED WITH ANY CONGENITAL ABNORMALITY.		
15. ARE YOU OR ANY OF YOUR DEPENDENTS NOW NOT IN GOOD HEALTH OR FREE FROM PHYSICAL IMPAIRMENT OR DEFORMITY.		

INCLUDE THE SYMPTOMS, TYPE AND DATE OF TREATMENT, AND NAME AND ADDRESS OF PHYSICIAN FOR ANY QUESTIONS ANSWERED ABOVE WITH "YES". (IF EXTRA SPACE IS NEEDED, SIGN, DATE, ATTACH ADDITIONAL SHEETS.)

AGREEMENT AND AUTHORIZATION

I CERTIFY THAT ALL THE INFORMATION I HAVE GIVEN ON THIS HEALTH STATEMENT IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT MY ANSWERS TO THE QUESTIONS CONTAINED IN THIS HEALTH STATEMENT WILL BE USED TO DETERMINE ELIGIBILITY FOR THE COVERAGE MARKED ABOVE. I FURTHER UNDERSTAND THAT IF ANY MATERIAL INFORMATION IS OMITTED FROM THE HEALTH STATEMENT, IT COULD PROVIDE THE BASIS TO REFUSE OR RESCIND COVERAGE AND TO REFUND ANY PREMIUMS PAID AS THOUGH COVERAGE HAD NEVER BEEN IN FORCE.

I AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL, CLINIC, OR OTHER MEDICALLY RELATED FACILITY, INSURANCE COMPANY OR OTHER ORGANIZATION, INSTITUTION OR PERSON, THAT HAS ANY RECORDS OR KNOWLEDGE OF ME OR MY HEALTH OR THAT OF MY PROPOSED DEPENDENTS, TO GIVE THE INSURANCE COMPANY ANY SUCH INFORMATION. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

SIGNATURE OF EMPLOYEE (Not Dependent)	DATE SIGNED	SIGNATURE OF SPOUSE (If applying for coverage)	DATE SIGNED
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