

**Personal Health Statement
(ATTACH TO APPLICATION FORM)**

BLUECHOICE HEALTHPLAN • COMPANION LIFE INSURANCE COMPANY

(Companion Life is a separate life insurance company that does not provide BlueChoice HealthPlan products or services. Companion Life is solely responsible.)

EMPLOYER _____ GROUP NUMBER ---

NAME OF EMPLOYEE _____ SOCIAL SECURITY NUMBER --

1. In the last 10 years have you or anyone to be covered been diagnosed with, been treated or advised to seek treatment or testing for, had symptoms related to, or had any of the following:

CONDITION	YES	NO	CONDITION	YES	NO
AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or HIV (Human Immunodeficiency Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or seizures Date of last seizure _____ Type of seizure/epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Sudden weight loss, night sweats, persistent fever, fatigue, or lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	Severe or persistent headaches or migraines	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug dependency, abuse, or overdose	<input type="checkbox"/>	<input type="checkbox"/>	Depression, anxiety or other mental condition	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis (type) _____	<input type="checkbox"/>	<input type="checkbox"/>	Nervous system disorder, fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of spine, discs, back or muscles	<input type="checkbox"/>	<input type="checkbox"/>	Muscular dystrophy, multiple sclerosis, cerebral palsy, Parkinson's disease or Alzheimer's disease.	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of bones, joints, tendons, or ligaments	<input type="checkbox"/>	<input type="checkbox"/>	Disorders of the breasts, genitals or reproductive system	<input type="checkbox"/>	<input type="checkbox"/>
Asthma, allergies, or other respiratory condition	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones or other disorders of urinary system	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, Tuberculosis, or shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Hernia or prostate disorder	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of eyes, ears, nose, or throat	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear or menstrual disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or other malignant tumor	<input type="checkbox"/>	<input type="checkbox"/>	Angina, heart attack, coronary artery disease or other disorders of the heart	<input type="checkbox"/>	<input type="checkbox"/>
Tumor, cyst, or other growth	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure Date diagnosed _____ Last 3 readings _____ Dates _____ / _____ / _____ Medications _____	<input type="checkbox"/>	<input type="checkbox"/>
Colitis, Crohn's disease, diverticulitis or other intestinal disorder	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Gall stones or disorders of gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins, thrombosis, leg ulcers or other disorders of the circulatory system	<input type="checkbox"/>	<input type="checkbox"/>
Disorders of liver or spleen If hepatitis, specify type _____	<input type="checkbox"/>	<input type="checkbox"/>	Anemia, hemophilia, or other blood disorder Specify type _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers, stomach or other digestive disorders	<input type="checkbox"/>	<input type="checkbox"/>	Birth defect or deformity	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Controlled by diet only <input type="checkbox"/> Yes <input type="checkbox"/> No Daily insulin dosage _____ Type and amount of oral medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Any other injury, disease or disorder not noted above?	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid, goiter, pituitary, or adrenal gland disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Paralysis or neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>			
Stroke or TIA (transient ischemic attack)	<input type="checkbox"/>	<input type="checkbox"/>			

2. For any condition checked Yes, please complete this section. Also list any medications not previously mentioned that are prescribed by a physician. If more space is needed attach a separate sheet.

Patient's Name	Doctor's Name, Address & Phone #	Condition	Dates	Treatment/Medication	Results/Prognosis
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I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form a part of my application for group insurance and that such insurance will not become effective until such application has been approved by BlueChoice HealthPlan and/or Companion Life Insurance Company.

Applicant's Signature _____ Date: _____