Medical Assessment Form

Any information disclosed cannot be used to deny medical coverage to any individual within an approved group
(valid for 60 days)

FILL OUT FORM IN INK
ALL QUESTIONS MUST BE ANSWERED
RETURN TO YOUR HR DEPARTMENT

A. EMPLOYEE INFORMATION

Business Name _____

Employee's Name _____ Job Title _____

Home Address of Employee _____ Full-time Hire Date _____
City State Zip

LIST ALL FAMILY MEMBERS TO BE INSURED – *If additional space is needed, attach, date and sign a separate sheet.*

	Name First MI Last	Sex M/F	Date of Birth MM/DD/YYYY	Height	Weight	Tobacco, nicotine or E-cigarette use	If last name different explain relationship*
Employee						☐Yes ☐No	☐ Married ☐ Single
Spouse						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	
Child						☐Yes ☐No	

** If last name is different from employee, legal documentation must be provided.*

B. THE FOLLOWING QUESTIONS MUST BE ANSWERED ACCURATELY AND COMPLETELY

* Please provide details in section C

Have you or anyone applying for coverage consulted with or been examined, diagnosed, or treated by any healthcare professionals during the last 5 years for any illness, injury or health condition listed below? Check all that apply and explain fully in section C.

1. ☐ **Cancer / tumor / cyst** – ☐Brain ☐Breast ☐Esophagus ☐Stomach ☐Colon ☐Leukemia ☐Lymphoma ☐ Multiple myeloma ☐Kidney ☐Liver ☐Lung ☐Melanoma ☐Pancreas ☐Prostate ☐ Testicular ☐ Cervical ☐ Uterine ☐ Throat ☐ Thyroid ☐Other cancer (type/location _____) ☐Non-malignant tumor (type/location _____)
   Diagnosis date _____ Cancer stage (0-4; if known) ___ Cancer category (if known) ☐ In situ ☐ localized ☐ regional ☐ distant
   Treatment: ☐Surgery date _____ ☐Chemo timeframe _____ – _____ ☐Radiation timeframe _____ – _____
   ☐ Remission ☐Yes ☐No If yes, provide date of remission _____
2. ☐ **Heart / vascular –** ☐ Aneurysm (location _____) ☐Blocked arteries (e.g. carotid, heart, abdomen, legs) ☐Heart attack ☐Heart valve disorder ☐Congestive heart failure ☐Cardiomyopathy ☐Irregular or abnormal heart rhythm ☐Stroke ☐Vasculitis (type _____) ☐Bypass / angioplasty / stent (location _____) ☐Pacemaker or cardiac defibrillator ☐ Other*
3. ☐ **Blood / clotting disorder –** ☐Hemophilia (specify type below) ☐Anemia (specify type below; e.g. sickle cell, hemolytic, aplastic) ☐Blood clots ☐ Other*
4. ☐ **Reproductive / gynecological –** ☐Current pregnancy: specify if it's a spouse, dependent child or other expectant parent even if not listed on the application (due date _____, if multiples # ____, any complications _____) ☐ Intending to adopt ☐Infertility ☐ Other*
5. ☐ **Gastrointestinal / endocrine –** ☐Diabetes ☐Crohn's / ulcerative colitis ☐Autoimmune hepatitis ☐Cirrhosis ☐Pancreatitis ☐Hepatitis B (specify acute or chronic) ☐Hepatitis C (if cured, when did treatment end? _____) ☐Growth disorder ☐Adrenal, pituitary, thyroid gland disorder (specify type below) ☐Other disorders of the gallbladder, stomach, pancreas, liver, colon*
6. ☐ **Brain / neurological –** ☐Amyotrophic lateral sclerosis ☐Cerebral palsy ☐Neuropathy / polyneuropathy ☐Multiple sclerosis ☐Myasthenia gravis ☐Muscular dystrophy ☐Brain and/or spinal cord disorder or injury ☐Paralysis, quadriplegia, paraplegia ☐Other*
7. ☐ **Immune / dermatology –** ☐HIV or Aids ☐Immunodeficiency disorder ☐Connective tissue disorder (specify type below; e.g. lupus, scleroderma) ☐Heredity angioedema ☐Skin disorder (specify type below; e.g. psoriasis, eczema, ulcers, infections) ☐Other*
8. ☐ **Lung / respiratory –** ☐Cystic fibrosis ☐COPD, chronic bronchitis, emphysema ☐Pulmonary hypertension ☐Pulmonary fibrosis ☐Asthma ☐Sarcoidosis ☐Other*
9. ☐ **Urinary / kidney –** ☐Kidney disease / disorder (specify type below) ☐Kidney failure ☐Dialysis: date started _____ ☐Possible dialysis within the next 18 months ☐Bladder disorder ☐Prostate disorder ☐Other (specify details below)

10. ☐ **Musculoskeletal –** ☐Rheumatoid arthritis ☐Psoriatic arthritis ☐Disorder of the back / neck / spine ☐Chronic pain disorder ☐Disorder of the joints (specify location; e.g., hips, knees, shoulders) ☐Osteomyelitis ☐Amputation ☐ Other*

11. ☐ **Mental health / Substance abuse –** ☐Alcohol and/or drug abuse (specify type below) ☐Eating disorder ☐Anxiety / depression ☐Bipolar disorder ☐Schizophrenia ☐Suicide attempt ☐Oppositional defiant / conduct disorder ☐Autism ☐ABA therapy ☐ Other*

12. ☐ **Transplant –** ☐Organ or bone marrow / stem cell transplant already performed (date _____) ☐Future transplant planned / scheduled (date _____) ☐Transplant discussed / recommended / possible within the next 18 months ☐Transplant complications ☐Other*

13. ☐ **Birth / inherited conditions –** ☐Premature birth (gestational age:____ # weeks) ☐Congenital birth defect ☐Genetic / metabolic disorder ☐Any syndrome* ☐Other*

14. ☐ **Eyes / ears / nose / throat –** ☐Acoustic neuroma ☐Cataracts ☐Cleft lip / palate ☐Deviated septum ☐Glaucoma ☐Retinopathy ☐Chronic ear infections ☐Chronic sinusitis ☐Other*

15. ☐ **Incapacitated –** ☐Disabled ☐Handicapped ☐Congenital disorder ☐Other*

16. ☐ **Medications –**

- ☐ Have you or any of your dependents ever received IV infusion medications that are typically administered by a doctor or nurse in a doctor's office, hospital, other health care facility, or at home?
- ☐ Have you or any of your dependents taken specialty medications? Specialty medications are high-cost oral or injectable medications used to treat complex or rare chronic conditions such as cancer, rheumatoid arthritis, hemophilia, HIV, psoriasis, inflammatory bowel disease, and hepatitis C. These can also be defined as drugs that cost greater than $700 per month supply.

17. ☐ **Other* –** ☐Hospitalizations in the past 5 years ☐Other conditions not addressed elsewhere in the application ☐Future surgeries or hospitalizations discussed, planned, recommended or scheduled in the next 18 months

C. *PROVIDE COMPLETE DETAILS BELOW FOR ALL HEALTH CONDITIONS SELECTED ABOVE AND THOSE NOT LISTED

If additional space is needed, attach, *date and sign* a separate sheet. Write N/A if not applicable.

Ques. No.	Enrollee Name	Medical Condition	Treatment / Medication (include surgery, hospitalization, DME, supplies, and all medicines)	Dates Treated From MM/YY To MM/YY	Is treatment ongoing? If **yes**, provide details of any current or future treatment

Please provide COMPLETE names and addresses of all attending doctors/hospitals/clinics and the condition for which treatment was received

Name of Doctor (including Family Practitioner)/Hospital/Clinic	Address	Phone Number	Medical Condition / Enrollee Name

D. APPLICANT'S STATEMENT – READ CAREFULLY:

I certify that all information provided in this application is full, complete and true to the best of my knowledge, information and belief. If I become aware of any new information that would change any answer on this form after I have completed this enrollment form but before the effective date of coverage, I agree to provide that information to BANN's Administrator as soon as possible. I understand that any material misstatement or failure to provide requested information may be used as a basis of termination of my coverage. When applicable, I authorize my employer to deduct premiums from my earnings. I understand that no coverage will be effective until this application has been approved by the insurer. I understand that this information is not valid after 60 days from completion.

Employee Signature: _____ Date: _____