HEALTH CARE PROVIDERS GROUP INSURANCE PLAN™
STATEMENT OF HEALTH

(Please answer ALL questions)

2

Employee information only

Last Name _____ First Name _____ Hospital _____ Dept _____

Information about you and your dependents

1. List all persons eligible for coverage including yourself (in shaded boxes), spouse, and all eligible dependents)

Name of eligible persons (include yourself on the first line)	Relationship to you	Birthdate dd/mm/yyyy	Height feet/inches	Weight pounds	Smoker (Y/N)
	Employee				

2. Have you or any of your dependents ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy or naturopathy, etc) about, been treated for, or had any known indication of any of the following:
(If "Yes", please circle which and give details in 6, over page).

		Yes	No			Yes	No
(a)	Circulatory or Heart or Vascular disease, High Blood Pressure, Angina, Stroke or TIA (mini stroke), Elevated cholesterol, Chest Pain or Heart Murmur?	☐	☐	(i)	Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)?	☐	☐
(b)	Arthritis, Gout, Rheumatism, Osteoporosis/Osteopenia, disorder of joints or limbs or spine, joint or muscle pain?	☐	☐	(j)	Skin Disorder including Acne, Rosacea, Psoriasis or Eczema?	☐	☐
(c)	Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia, Reflux or persistent Heart Burn?	☐	☐	(k)	Infertility, Reproductive disorder, Menopause, Disorder of Breasts, Ovaries, Cervix or Uterus?	☐	☐
(d)	Stomach, Intestinal, Kidney, Bladder or Liver Disorder including Hepatitis?	☐	☐	(l)	Headaches/migraines, Dizziness, Fainting, Disorder of the brain or nervous system?	☐	☐
(e)	Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures or Paralysis?	☐	☐	(m)	Sexually Transmitted Disease or infection (STD's or STI's) or recurring infections (including Cold Sores/Herpes)?	☐	☐
(f)	Alcohol or drug dependency?	☐	☐	(n)	Diabetes or Endocrine disorder?	☐	☐
(g)	Lung Condition, Respiratory Condition including COPD, Asthma or Allergies, Sleep Apnea?	☐	☐	(o)	Disorder of the eyes, ears, nose or throat?	☐	☐
(h)	Cancer, Tumor or any other growth?	☐	☐	(p)	Anemia or low iron?	☐	☐

3. Have you or any of your dependents ever been treated or hospitalized for or had any known indication of any Physical Impairment, Condition, Disease or Disorder not stated above? If "Yes", please give details in 6 over page. ☐ ☐

4. Are you or any of your dependents currently taking prescription or non-prescription medications of any kind or been advised by a physician or Alternative Health Care Provider to take medication of any kind? If "Yes", please give details in 6 over page. ☐ ☐

5. Have you or any of your dependents ever been advised to have an investigation, hospitalization or surgery which has not yet been completed? If "Yes", please give details in 6 over page. ☐ ☐

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN™
STATEMENT OF HEALTH (CONT.)
(Please answer ALL questions)

6.

Question Number (previous page)	Employee or Dependent's Name	Nature of Illness	Date of Onset and Recovery dd/mm/yyyy	Type of Medication and/or Treatment	Approx. Monthly Cost of Medication	How often do you see your Doctor for treatment?

NOTE: Based on your medical history or that of a dependent, coverage may be declined or modified to exclude certain prescription drugs. Coverage that is approved will commence no earlier than the first of the month following final approval of the application of which this statement of health is part.

Employee's Declaration

I hereby declare that all the statements contained in this application for the Health Care Providers Group Insurance Plan™ are true and complete and together with any other forms signed by me in connection with this application, form the basis for any agreement issued thereunder. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my or my dependents health to release such information to the Plan Administrator. I understand and agree that information related to the administration of benefits may be provided to third parties to whom access has been granted or those authorized by law. A photocopy of this signed authorization shall be as valid as the original. I understand and agree that any injury that occurred on or before the date of this application or any medical condition, the signs of which first appeared on or before the date of this application may not be covered by the agreement. I understand it is my obligation to inform HCP of a change in my health or that of my spouse or any listed dependent children due to either injury or illness which occurs after the date of application and prior to the date of approval. Failure to disclose such information could result in denial of a claim and the cancellation or modification of this agreement. Health Care Providers Group Insurance Plan™ reserves the right to recover any claims paid due to the applicant's failure to disclose an injury or medical condition that existed on or before the date of this application. I understand that Health Care Providers Group Insurance Plan™ reserves the right to audit claims.
NOTE: This form is valid for ONLY 60 days from the date it is signed!

Dated at _____ this _____ day of _____ 20 _____
(City/Town)

Employee's Signature: **X** _____

Privacy Statement

All information about the insurability of you and your dependents is considered confidential. HCP is a business name registered to Hardiman Mount & Associates Insurance Brokers Limited. We are committed to protecting the privacy, confidentiality, accuracy and security of the personal information that is collected, used, retained and disclosed in the course of conducting business.