



STATEMENT OF HEALTH OPTIMUM COVERAGE

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TO PROCESS YOUR APPLICATION, ALL APPLICABLE FIELDS ON THIS FORM MUST BE COMPLETED

First Name: _____ Last Name: _____
 Hospital: _____ Occupation: _____

General Information (Employee And Dependants)					
Please complete the following information for all persons eligible for coverage including yourself, your spouse and all eligible dependants.					
Relationship:	Name (First, Last):	Date Of Birth (MM/DD/YYYY):	Height (Ft/In):	Weigh (lbs):	Smoker (Y/N):
Employee:					
Spouse:					
1 st Child:					
2 nd Child:					
3 rd Child:					
4 th Child:					

Statement Of Health Questionnaire

Have you or any of your dependants ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy, naturopathy, etc.) about, been treated for, or had any known indication of any of the following:

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Circulatory, heart or vascular disease. High blood pressure, angina, stroke or TIA (mini stroke). Elevated cholesterol, chest pain or heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> | 2. Immune disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Arthritis, gout, rheumatism, osteoporosis/osteopenia. Disorder of joints, limbs or spine. Joint or muscle pain? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Skin disorder including acne, rosacea, psoriasis or eczema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Colitis, Crohn's, irritable bowel syndrome (IBS), ulcers, hernia, reflux or persistent heart burn? | <input type="checkbox"/> | <input type="checkbox"/> | 6. Infertility, reproductive disorder, menopause, disorder of breasts, ovaries, cervix or uterus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Stomach, intestinal, kidney, bladder or liver disorder including hepatitis? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Headaches, migraines, dizziness, fainting, disorder of the brain or nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Mental, anxiety, emotional disorder, depression, Alzheimer's, dementia, Parkinson's, seizures, paralysis ADD or ADHD? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Sexually transmitted disease (STD) or infection (STI) or recurring infections (including cold sores or herpes)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Alcohol or drug dependency? | <input type="checkbox"/> | <input type="checkbox"/> | 12. Diabetes or endocrine disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Lung condition, respiratory condition including COPD, asthma, allergies or sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> | 14. Disorder of the eyes, ears, nose or throat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Cancer, tumor or any other growth? | <input type="checkbox"/> | <input type="checkbox"/> | 16. Anemia or low iron? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you or any of your dependants ever been treated or hospitalized for or had any known indication or any physical impairment, condition, disease or disorder not stated above? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Are you or any of your dependants 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? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you or any of your dependants ever been advised to have an investigation, hospitalization or surgery which has not yet been completed? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

If you answered yes to any of the questions above, please provide additional details on the overpage, and circle which diagnosis or disorder applies to you or your dependants.

