

# HEALTH NET EMPLOYER HEALTH STATEMENT

For *New Firms* only, please complete if you have 10 or more Owners/Employees enrolling with Health Net

Company Name \_\_\_\_\_ Member of (Exchange/Association) \_\_\_\_\_

Requested effective date \_\_\_\_\_

# of owners/employees enrolling with Health Net \_\_\_\_\_

## HEALTH QUESTIONNAIRE

ALL FIRMS MUST ANSWER "YES" OR "NO" TO THE FOLLOWING QUESTIONS

THIS APPLIES TO NEW FIRMS TO OUR PROGRAM ENROLLING 10 OR MORE OWNERS/EMPLOYEES WITH HEALTH NET

1.	To your knowledge, is there any employee, dependent of an employee, or person to be covered who has received more than \$5,000 of medical care in the past two (2) years?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2.	To your knowledge, is any employee, dependent of an employee, or person to be covered unable to work due to injury or illness?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3.	To your knowledge, are there any current pregnancies or recent hospitalization for any employee, dependent of an employee, or person covered?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4.	To your knowledge, has any employee, dependent of an employee, or person to be covered ever had, consulted for, had treatment rendered, been advised to have treatment or received treatment, or been hospitalized for any of the following conditions?  <div style="display: flex; justify-content: space-between; font-size: small;"> <div>Cardiovascular disease</div> <div>Heart attack</div> <div>Disorder of the kidney or stomach</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <div>Cancer</div> <div>Diabetes</div> <div>Disorder of the intestines or liver</div> </div> <div style="display: flex; justify-content: space-between; font-size: small;"> <div>Mental or nervous condition</div> <div>Respiratory disorders</div> <div>Central nervous system disorders</div> </div>	<input type="checkbox"/> YES <input type="checkbox"/> NO
5.	To your knowledge, has any employee, dependent of an employee, or person to be covered ever been diagnosed as having AIDS or AIDS-related complex (ARC) by a medical professional?	<input type="checkbox"/> YES <input type="checkbox"/> NO
6.	For each "Yes" answer, please provide the person(s) name and submit their completed employee health questionnaire (found on the back of this page)	
	1.	2.
	3.	4.

## UNDERWRITING CRITERIA

### GENERAL CONDITIONS

The issuance of coverage and/or a group policy is subject to underwriting review and approval by Health Net. The initial quoted rates are subject to the Health Net review and revision based on actual enrollment and any other variations in the firm from conditions outlined in the Underwriting Assumptions.

Coverage will be effective on the noted effective date if the application is accepted and approved by Health Net as appropriate within specified time requirements.

7. SIGNATURE

OWNER / OFFICER

PRINT NAME

TITLE

DATE

### HEALTH NET USE ONLY

Underwriting Response:

Date:



# INDIVIDUAL HEALTH QUESTIONNAIRE

**CHECK ONE**

- Initial Enrollee
- Late Enrollee(s)
- Existing Member

**FOR FIRMS WITH 10 OR MORE ENROLLING:**

All owner/employees with a "Yes" answer should complete this form for themselves and/or their dependents.

**FOR FIRMS WITH 6-9 OWNERS/EMPLOYEES ENROLLING:**

each Employee should complete this form for themselves and/or their dependents.

PLEASE PROVIDE COMPLETE INFORMATION TO ASSURE TIMELY ADMINISTRATION OF CLAIMS

Information provided will not cause medical plan enrollment denial

(If you and/or your eligible dependents have chosen to decline health coverage you are not required to complete this questionnaire)

## 1. EMPLOYEE INFORMATION

Employee Name	Gender	Height	Weight	Social Security Number	DOB	Employer Name
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## 2. HEALTH QUESTIONNAIRE

Please answer YES or NO to each of the following questions for yourself and each of your dependents. *For each YES answer, Please explain and provide complete details. HAVE YOU OR ANY OF YOUR DEPENDENTS:*

Been diagnosed with, treated for, or had treatment recommended within the last five (5) years for any of the following:

	Yes	No	Other Conditions / Information:	Yes	No
a. Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	m. Are you or any dependents now pregnant? If yes, First pregnancy? Complications with this or any prior pregnancy?	<input type="checkbox"/>	<input type="checkbox"/>
b. Hypertension?	<input type="checkbox"/>	<input type="checkbox"/>	n. Any other medical condition that has not been disclosed above? If so, describe in detail below.	<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer, tumor or other malignancy?	<input type="checkbox"/>	<input type="checkbox"/>	o. Have you or your dependents smoked in the last 2 years? If yes, date stopped: _____	<input type="checkbox"/>	<input type="checkbox"/>
d. Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?	<input type="checkbox"/>	<input type="checkbox"/>	p. Are you or any of your dependents taking any medication (except antibiotics or contraceptives) that require a prescription by a Physician?	<input type="checkbox"/>	<input type="checkbox"/>
e. Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?	<input type="checkbox"/>	<input type="checkbox"/>	q. Have you or your dependents gained or lost more than 20 pounds in the last year? <input type="checkbox"/> Gained _____ <input type="checkbox"/> Lost _____	<input type="checkbox"/>	<input type="checkbox"/>
f. AIDS, AIDS-related complex or other immune deficiency disorders, infections or chronic infection problems?	<input type="checkbox"/>	<input type="checkbox"/>	r. Are you actively at work at least 20 hours per week?	<input type="checkbox"/>	<input type="checkbox"/>
g. Alcohol or substance abuse, metal/nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>	s. Have you or your dependents been admitted to a hospital or had surgery in the past five (5) years?	<input type="checkbox"/>	<input type="checkbox"/>
h. Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?	<input type="checkbox"/>	<input type="checkbox"/>	t. Have you or your dependents been told that it may be necessary to be admitted to the hospital or have surgery in the future?	<input type="checkbox"/>	<input type="checkbox"/>
i. Diabetes, cystic fibrosis, albumin or sugar in the urine or other endocrine problems?	<input type="checkbox"/>	<input type="checkbox"/>			
j. Asthma, emphysema, tuberculosis, pleurisy or other diseases of the lungs?	<input type="checkbox"/>	<input type="checkbox"/>			
k. Paralysis, epilepsy, M.S. or other neuromuscular disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
l. Bleeding or blood disorders?	<input type="checkbox"/>	<input type="checkbox"/>			

## 3. DETAILED EXPLANATIONS

Item No.	Name of Person Treated	Height/Weight	Diagnosis/Condition	Type of Treatment	Medications/Dosage	Treatment Provider	<input type="checkbox"/> Still under treatment Treatment dates
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)
		Height				Physician Name	Date treatment began
		Weight				Hospital/Facility Name	Date ended (if applicable)

## 4. Signature

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that the Health Statement is part of my request for health coverage. Information provided will not cause medical plan enrollment denial. However, I understand that if I have misrepresented or omitted any material fact, my coverage may be cancelled or the contract rescinded.

Employee Signature

Date