

# 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 stomach</div> <div>Heart attack</div> <div>Disorder of the kidney or</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:
------------------------	-------