PUBLIC EMPLOYEES HEALTH PROGRAM

GROUP TERM LIFE HEALTH STATEMENT

Employee Name: ____________________ Social Security Number: ____________________

Complete this form for the spouse or one for each dependent. This information is required if applying for Spouse or Dependent coverage after 60 days from hire date, birth date or marriage date. This is also required for Spouse coverage in excess of $15,000.

Name (Last, First, M. I.) ____________ Date of Birth: ________ Height (Ft. In.): ________ Weight ________

Relationship To Employee: ____________________ Occupation: ____________________

1. Have you ever had symptoms, been diagnosed with, or been treated for:

a. High blood pressure	☐ Yes	☐ No
b. Seizures or convulsions	☐ Yes	☐ No
c. Mental or nervous conditions	☐ Yes	☐ No
d. Lung or respiratory disorders	☐ Yes	☐ No
e. Digestive or rectal disorders	☐ Yes	☐ No
f. Blood or blood vessel disorders	☐ Yes	☐ No
g. Urinary tract disorders	☐ Yes	☐ No
h. Skeletal, spine, joint or muscle disorders	☐ Yes	☐ No
i. Thyroid, breast or other glandular disorders	☐ Yes	☐ No
j. Rheumatic fever or heart disorders	☐ Yes	☐ No
k. Chest pain or circulatory disorders	☐ Yes	☐ No
l. Reproductive organ disorders	☐ Yes	☐ No
m. Substance or alcohol abuse	☐ Yes	☐ No
n. Cancer or tumors	☐ Yes	☐ No
o. Ulcer	☐ Yes	☐ No
p. Colitis	☐ Yes	☐ No
q. Diabetes	☐ Yes	☐ No

2. Have you ever had a surgical procedure or been advised to have surgery which has not been completed at this time?	☐ Yes	☐ No
3. Have you consulted or been attended by a physician or practitioner and/or taken prescription medication(s) within the past five years?	☐ Yes	☐ No
4. Have you had or currently have any known physical deformities, or physical or mental impairments, disorders or ill health not mentioned in question #1?	☐ Yes	☐ No
5. Have you ever been denied life or health insurance coverage, or received an increased premium for health reasons?	☐ Yes	☐ No
6. Have you had an electrocardiogram, x-ray, laboratory study, blood study, body scan or diagnostic procedure within the past three years?	☐ Yes	☐ No
7. In the past ten years, have you sought or received treatmetnfor advise for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or AIDS related diagnosis or opportunistic diseases, including Pneumocystis Carinii Pneumonia or Kaposi's Sarcoma?	☐ Yes	☐ No
8. Have you ever tested HIV positive?	☐ Yes	☐ No
9. If female, are you pregnant? If yes, expected date of delivery: ________	☐ Yes	☐ No
10. Tobacco Usage		
a. Do you currently smoke cigarettes? If yes, ____ per day?	☐ Yes	☐ No
b. Have you ever smoked cigarettes? If yes, last date smoked ________	☐ Yes	☐ No
c. Have you used any tobacco products in the past 10 years?	☐ Yes	☐ No

Give complete details for all "Yes" answers to above questions. Provide complete names and phone numbers for all physicians.

Question No.	Disease, injury or Medical Condition	Treatment / Medication / Dosage (for substance/ alcohol abuse, provide date of last consumption)	Treatment Dates		Hospitalized?		Attending Physician (doctor name and phone number)	Degree of Recovery
			From	To	Yes	No		

Employee Agreement & Signature

I represent that all information is true and correct. I understand any materially incorrect, incomplete or misstated facts may result in the recision of coverage issued in reliance on information given to PEHP, and there will be no benefits payable. By signing below I hereby: (1) authorize the deduction of Group Term Life premiums; (2) authorize PEHP to obtain from medically related practitioners or facilities, insurance companies, the Medical Information Bureau, or other organizations, institutions or persons any information necessary to process this application and determine my insurability; (3) understand the coverage applied for replaces any previous Employee, Spouse or Dependent Children Term Life coverage offered by PEHP; (4) agree to the terms and conditions in the PEHP Group Term Life Master Policy.

EMPLOYEE SIGNATURE	DATE	SPOUSE SIGNATURE (Required if applying for Spouse Term Life Coverage)	DATE

GROUP TERM LIFE HEALTH STATEMENT (CONTINUED)

Employee Name: ______________________ Social Security Number: ______________________

Complete this form for the spouse or one for each dependent. This information is required if applying for Spouse or Dependent coverage after 60 days from hire date, birth date or marriage date. This is also required for Spouse coverage in excess of $15,000.

Name (Last, First, M. I.) ______________________ Date of Birth: __________ Height (Ft. In.): __________ Weight __________

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