UNIVERSAL MEDICAL APPRAISAL FORM

GROUP NAME:______________________________________

This form must be completed by each employee applying for coverage and must include All dependent(s).

APPLICANT INFORMATION- for enrolling coverage(s) only							
	Name	M/F	Soc. Sec. #	Zip Code	Date of Birth	Height	Weight
Employee:							
Home Phone #							

Dependent Information:						
	Name	M/F	Soc. Sec. #	Date of Birth	Height	Weight
Spouse:						
Child:						
Child:						
Child:						
Child:						
Child:						
Child:						

LEVEL OF BENEFITS APPLIED FOR (Please Mark One):

_____Employee Only _____Employee & Child _____Employee & Spouse _____Employee & Child(ren) _____Family

WAIVER OF COVERAGE:

Complete this section if you wish to decline coverage offered for you and/or your family member(s)

For: _____Myself _____ My Dependent Children

_____My Spouse _____Myself & all Family Members

Reason for Declining Coverage: _____ Have Not Met Employer's Eligibility

_____ Insured Under Spouse's Contract with the following Insurance Carrier ____________________

_____ Other - ____________________

Employee Signature: ______________________________ Date: __________

Employee Name: ______________________________

Medical Information: Have you or your dependents listed above EVER had any signs or symptoms, or been told to have, or been treated or diagnosed with a condition for which consultation was or will be sought for any of the conditions listed below? Circle "yes" or "no" to all questions. Give details for all answered "yes" in the explanation section on page 3.

1. Benign Conditions -Tumor, Cyst or Growth Y N
If Yes, list Site ____

2. Cancers - List status in Explanation Section Y N
If Yes, list Site ____

3. Heart/Lung
Aneurysm ____ Y N
Arteriosclerosis ____ Y N
Chest Pain/Angina ____ Y N
Congenital Heart Disease ____ Y N
Congestive Heart Failure ____ Y N
Heart Attack ____ Y N
High Cholesterol/Triglycerides ____ Y N
Hypertension ____ Y N
Irregular Heart Beat ____ Y N
Ischemic Heart Disease ____ Y N
Valvular Disease ____ Y N
Apnea ____ Y N
Asthma/Allergy ____ Y N
Cystic Fibrosis ____ Y N
Emphysema/COPD ____ Y N
Tuberculosis ____ Y N

4. Heart/Lung Treatments
Angioplasty ____ Y N
Bypass ____ Y N
Cardiac Ablation ____ Y N
Cardiac Catherization ____ Y N
Pacemaker Implantation ____ Y N
Heart Valve Replacement ____ Y N

5. Blood Disorders
Anemia - Type ____ Y N
Hemochromatosis ____ Y N
Hemophilia ____ Y N
Other - Type ____ Y N

6. Renal
Blood in Urine ____ Y N
Dialysis ____ Y N
Kidney, Kidney Stones, Urinary Disorder ____ Y N
Polycystic Kidney Disease ____ Y N
Renal Failure - Acute ____ Chronic ____ Y N

7. Immune
AIDS/ARC-AIDS Related Complex/HIV ____ Y N
Autoimmune Illness-Type ____ Y N
Systemic Lupus ____ Y N

8. Endocrine
Diabetes - Juvenile ____ Adult ____ Y N
Type 1 ____ Type 2 ____
Diet Controlled ____ Oral Meds ____
Insulin ____ Units per day ____
Last Three (3) Blood Sugar Readings
____ ____ ____
Last Hemoglobin A1-C (Hb A1-C) Result ____
Date of Last Hb A1-C: ____/____/____
Growth Hormone ____ Y N
Pancreatitis ____ Y N
Pituitary Disorder ____ Y N
Thyroid/Adrenal Disorder ____ Y N

9. Digestive/Intestinal
Cirrhosis of Liver ____ Y N
Colonoscopy ____ Y N
Colostomy ____ Y N
Crohn's Disease ____ Y N
Gastric Bypass ____ Y N
GERD/Peptic Ulcer ____ Y N
Hepatitis Type - A ____ B ____ C ____ Y N
Ulcerative Colitis ____ Y N

10. Neurological
Alzheimer's ____ Y N
Cerebral Palsy ____ Y N
Down's Syndrome ____ Y N
Epilepsy/Seizures ____ Y N
Grand Mal ____
Petit Mal ____
Lou Gehrig's Disease (ALS) ____ Y N
Migraines ____ Y N
Multiple Sclerosis ____ Y N
Paralysis ____ Y N
Parkinson's Disease ____ Y N
Spina Bifida-Cystica ____ Occulta ____ Y N
Stroke ____ Y N

11. Psychological
Active Counseling/Psychotherapy ____ Y N
ADD/ADHD ____ Y N
Anxiety, Depression ____ Y N
Attempted Suicide ____ Y N
Bulimia, Anorexia ____ Y N
Psychosis ____ Y N
Schizophrenia, Bipolar, OCD ____ Y N
Substance Abuse ____ Y N
Any Mental Health Hospitalization ____ Y N

12. Muscular/Skeletal
Amputation-Of ____ Y N
Arthritis-Rheumatoid ____ Osteo ____ Y N
Degenerative Disc/Joint Disease ____ Y N
Fibromyalgia ____ Y N
Gout ____ Y N
Herniated Disc ____ Y N
Joint Replacement- Of ____ Y N
Muscular Dystrophy ____ Y N
Osteoporosis ____ Y N
Scoliosis ____ Y N

13. Reproductive (Female/Male)
Abnormal Pap Smear: Date ___/___/___ Y N
Date of Last Normal Pap Smear ___/___/___
Breast Disorder or Breast Implants ____ Y N
Endometriosis ____ Y N
Infertility ____ Y N
Invitro ____ GIFT ____
Other Reproductive ____ Y N
Ovarian Cyst/PCOS ____ Y N
Prostatitis/BPH ____ Y N
Sexually Transmitted Disease(s) ____ Y N
Pregnant-Due Date ___/___/___ Y N

If pregnant: Do you have or ever had:
Gestational Diabetes ____ Y N
Hypertension ____ Y N
Incompetent Cervix ____ Y N
Multiple Birth Pregnancy ____ Y N
Prior Miscarriage ____ Y N
Pre Term Labor or Premature Birth(s) ____ Y N

14. Do you or any of your dependents have any other medical conditions not listed on questions #1 thru #13 that have been diagnosed or treated by a health care provider in the past 5 years? ________	Y	N
15. Cigarette or tobacco use If YES, type of product and how much per day________	Y	N
16. Have you or any of your covered dependents ever had or been advised to have an organ or bone marrow transplant? ________	Y	N
17. Have you or any of your dependents been hospitalized or had surgery within the past 5 years? ________	Y	N
18. Have you or any of your dependents been advised to have surgery which has not been performed yet? ________	Y	N
19. Are your or any of your dependents currently taking prescription medications that have not already been listed? If yes, please list patient's name, name of medication(s), dosage and reason for taking it.	Y	N
20. Have you been hired in the last 6 months? If so, have you or any of your dependents been treated by a health care provider six months prior to your hire date? ________	Y	N
21. Have you or any of your dependents ever been eligible for benefits from Workers' Compensation, Disability, or Subrogation for any of the conditions listed in the medical section above? ________	Y	N

If any of the previous questions #1 thru #21 were answered "yes" please indicate the referral number. Include for whom (ex: self, spouse, etc.) diagnosis, date of diagnosis, date of last treatment; indicate severity as well as any medications taken and dosage. If surgery is needed, please indicate reasoning and pending dates, etc.

Explanation Section:

Question #	Patient Name	Hospitalization Date (s)	Treatment Dates From/To		Diagnosis, Treatments, Prognosis, and Medications/Dosages

Additional Information:

I have read the entire Application and by signing this form, I declare that all information, statements and answers are true and complete for all listed individuals applying for coverage. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Employee Signature: ____________________ Date:__________