Oxford Health Plans®

CT Family Health Statement

Mailing Address: P.O. Box 7085, Bridgeport, CT 06601-7085 ▪ 800-444-6222
Corporate Address: 48 Monroe Turnpike., Trumbull, CT 06611 ▪ www.oxfordhealth.com

☐ NEW EMPLOYEE ADD ☐ EXISTING EMPLOYEE CHANGE

To Be Completed By Employer (Please print in ink all information requested on this application.)

NAME OF EMPLOYER	EMPLOYER STREET ADDRESS	CITY	STATE	ZIP

POLICY NUMBER	APPLICANTS OCCUPATION	EMPLOYEE SALARY	HOURS WORKED/WEEK	DATE OF FULL-TIME HIRE

To Be Completed By Employee (Complete for all family members applying for coverage.)

LAST NAME	FIRST NAME & MI	HEIGHT	WEIGHT	BIRTHDATE	SEX	FULL TIME STUDENT. IF YES, LIST SCHOOL.
					☐ MALE ☐ FEMALE	☐ YES ☐ NO
					☐ MALE ☐ FEMALE	☐ YES ☐ NO
					☐ MALE ☐ FEMALE	☐ YES ☐ NO
					☐ MALE ☐ FEMALE	☐ YES ☐ NO
					☐ MALE ☐ FEMALE	☐ YES ☐ NO
					☐ MALE ☐ FEMALE	☐ YES ☐ NO

EMPLOYEE STREET ADDRESS	CITY	STATE	ZIP	EMPLOYEE SOCIAL SECURITY NO	MARITAL STATUS ☐ SINGLE ☐ MARRIED

HOME PHONE	BUSINESS PHONE	BEST PLACE TO CALL DURING DAY ☐ HOME ☐ WORK	EMPLOYEE BIRTH PLACE	SPOUSE BIRTH PLACE

DOES YOUR SPOUSE HAVE GROUP COVERAGE ELSEWHERE? ☐ YES ☐ NO

DOES ANY PROPOSED INSURED HAVE OTHER HEALTH/LIFE COVERAGE? AMOUNT $________

HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED, RATED OR DECLINED? (SUBMIT DETAILS)

I WISH TO ENROLL FOR:

	EMPLOYEE	SPOUSE	DEPENDENT
HEALTH	☐	☐	☐
DENTAL	☐	☐	☐
LIFE	☐	☐	☐

IS ANY PERSON TO BE INSURED ELIGIBLE FOR MEDICARE? IF SO, PLEASE BE SPECIFIC.
☐ YES ☐ NO

MEDICARE A ____________ MEDICARE B ____________

AMOUNT OF LIFE INSURANCE REQUESTED

NAME OF BENEFICIARY

CURRENT LIFE AMOUNT

DISABILITY ☐

IS ANY PROPOSED INSURED CURRENTLY COVERED UNDER COBRA?

I DECLINE TO ENROLL FOR HEALTH COVERAGE DUE TO THE EXISTENCE OF OTHER GROUP HEALTH COVERAGE FOR: ☐ MYSELF ☐ SPOUSE ☐ DEPENDENT CHILD(REN)

I hereby request group insurance for myself and, if the plan provides dependent insurance, for my dependents indicated above and hereby authorize my employer or successor to make deductions from my earnings of the required contributions, if applicable, to apply toward the premiums for the insurance provided for in the policy of group insurance issued to my employer. I understand that if I and/or my dependents decline coverage and desire to participate in the plan at a later date, evidence of insurability satisfactory to the insurance company must be furnished.

X ______________________________
SIGNATURE OF EMPLOYEE

____
DATE

		YES	NO
1.	Are you now actively at work on a full-time basis?	☐	☐
2.	Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities?	☐	☐
3.	Have you or any dependent been hospitalized, advised to be hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason?	☐	☐
4.	Are you or any dependents to be covered currently pregnant? If yes, please give expected delivery date: ____________	☐	☐
5.	Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which this is used. ____________	☐	☐
6.	Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted?	☐	☐
7.	Have you or any dependents had medical expenses in excess of $5,000 in the last 12 months?	☐	☐

Have you or any dependent ever had or been told they had, been medically counseled, consulted or treated for any of the following: (Check "yes" or "no" and circle applicable disorder. Please provide details in the table below.)

	YES	NO
A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis or gout?	❑	❑
B. High blood pressure? If yes, provide most recent reading. _____/_____	❑	❑
C. Cancer, tumor or lymph node enlargement? (indicate type of cancer and location)	❑	❑
D. Sexually transmitted disease?	❑	❑
E. Mental, emotional, nervous disorder, stress related disorder, depression, anxiety, psychotherapy or counseling of any kind?	❑	❑
F. Brain disorder, neurologic problems, seizure disorder or epilepsy, any disorder of the central nervous system, stroke or paralysis?	❑	❑
G. Alcohol or drug use, abuse/and/or dependency?	❑	❑
H. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)?	❑	❑
I. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy?	❑	❑
J. Back, neck, bone, joint problems?	❑	❑
K. Lupus or arthritis? If so, please indicate type and severity of disability.	❑	❑
L. Tuberculosis?	❑	❑
M. Anemia or other disorder of the blood?	❑	❑

	YES	NO
N. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medication (if any).	❑	❑
O. Any disorder of the stomach, intestines, gallbladder or esophagus?	❑	❑
P. Any disorder of the lungs or respiratory system?	❑	❑
Q. Any disorder of the kidneys, bladder or urinary tract?	❑	❑
R. Any disorder of the liver or pancreas?	❑	❑
S. Any disorder of the endocrine system or glands?	❑	❑

T. Within the last two years, have you or any dependents ever had, been told they had, consulted or treated for any of the following:

	YES	NO		YES	NO
1. Asthma	❑	❑	7. Lyme Disease	❑	❑
2. Bronchitis	❑	❑	8. Nose/Throat Problems	❑	❑
3. Chiropractic Care	❑	❑	9. Sinusitis	❑	❑
4. Ear Problems	❑	❑	10. Skin Problems	❑	❑
5. Eye Problems	❑	❑	11. Thyroid/Goiter Problems	❑	❑
6. Headaches/Migraines	❑	❑	12. Urinary Tract Infections	❑	❑

U. Are you or any dependents planning any dental treatments?	❑	❑
V. Have you or any dependents had an examination or treatment for any other illness or injury other than those stated above?	❑	❑

DETAILS REGARDING ANY OF THE ABOVE STATED CONDITIONS (IF ADDITIONAL SPACE IS NEEDED, PLEASE ATTACH A SEPARATE PIECE OF PAPER)
ADDITIONAL PAPER ATTACHED ❑ YES ❑ NO

QUESTION NUMBER	NAME	ILLNESS OR NATURE OF COMPLAINT/ TREATMENT OR MEDICATION	DURATION DATES FROM MO/YR	TO: MO/YR	DEGREE OF RECOVERY*	NAME AND ADDRESS OF PHYSICIAN OR OTHER HEALTH CARE PROVIDER

**If not completely recovered, please indicate whether you are still receiving care.*

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief and understand that the said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of insurance.

Authorization to Obtain and Disclose Information in Connection with Eligibility for Group Insurance

TO: All providers of medical or dental services or supplies and their representative, the Medical Information Bureau, Inc. or other organizations, all insurers, medical or hospital service plans, prepaid health plans, employers, group policyholders or contractholders.

For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish any information available about the medical history, condition and treatment of the Employee, or any Dependents listed in this Health Statement, including but not limited to information related to psychiatric, alcohol and drug abuse, and HIV conditions.

I authorize the use of such information and the redisclosure of this information for the above purposes to its representatives, other organizations, and their representatives, any insurer, medical or hospital service plan, prepaid health plan or reinsurer. I also authorize the user to redisclose such information to any attending physician for treatment purposes and when necessary to inform the employee of the reason insurance was declined, to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, to any person who has an authorization specifically permitting the redisclosure and as may be permitted or required by law.

In order to assist my employer in selecting a health insurance plan, I acknowledge that this information may be presented to more than one insurer.

I agree that this authorization is valid for 30 months from the date below and a copy shall be as valid as the original. I know that I have a right to ask for and receive a copy of this authorization.

X _____ SIGNATURE OF EMPLOYEE

X _____ SIGNATURE OF SPOUSE

_____ DATE