

HEALTH STATEMENT 2 - 24 Enrolled Employees

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Name: _____ Employee Social Security #: _____ - _____ - _____

Name of Employer: _____

Employee: Height: _____ ft. _____ in. / Weight: _____ lbs. Spouse: Height: _____ ft. _____ in. / Weight _____ lbs.
(if coverage is to include spouse)

The following questions apply to **ALL** persons, including dependents, applying for coverage. Please provide details of any "yes" answers in the space provided or in an attached and signed document. In the past ten (10) years, have you or any persons listed on the application been diagnosed, treated or advised to seek treatment or testing, or had symptoms related to any of the following:

1. Blood Disorders/ Circulatory System
 Yes No

Anemia Aneurysm Angina/Chest Pain Angioplasty/By-Pass Blood Clot Carotid Artery Disease
 Congestive Heart Disease Coronary Artery Disease Elevated Cholesterol/Triglycerides Heart Attack Heart Murmur
 Hemophilia Irregular Heartbeat Phlebitis Polycythemia Vera Sickle Cell Stroke Varicose Veins
 High Blood Pressure (Last three readings/date (Ex. 120 / 80 03 / 13 / 04))
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

2. Bones/Injuries/ Muscles and Tissues
 Yes No

Rheumatoid Arthritis Arthritis (Other) Broken/Fractured Bones Bulging/Herniated Disc Fibromyalgia
 Lupus Necrosis Back/Neck Disorder (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

3. Congenital Anomalies/ Birth Defects
 Yes No

Cleft Lip Cleft Palate Polycystic Kidney Spina Bifida Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

4. Digestive System
 Yes No

Cirrhosis of Liver Hepatitis (specify type) _____ Other Liver Disorder (specify) _____
 Crohn's/Ulcerative Colitis Colon Disorders (specify) _____ Gallbladder
 Hernia (specify type) _____ Pancreatitis Reflux Ulcer (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

5. Endocrine System
 Yes No

Diabetes: Oral Medication _____ Dosage _____
 Daily Insulin Dosage AM Units _____ PM Units _____
 Last three Blood Sugar Readings (Ex. 140 03 / 13 / 04)
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Cystic Fibrosis Goiter Gout Pituitary Dwarfism Thyroid Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

6. Infectious/Parasitic Conditions
 Yes No

HIV/AIDS Sarcoidosis Tuberculosis Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

7. Mental Health Conditions/Substance Abuse
 Yes No

Alcohol Abuse Anxiety/Depression Bipolar Drug Abuse Anorexia Bulimia
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**8. Nervous System/
Sense Organs**
 Yes No

Alzheimer's Disease Cataract Cerebral Palsy Deviated Nasal Septum Chronic Ear Infection
 Epilepsy/Seizures Glaucoma Headaches/Migraines Multiple Sclerosis Muscular Dystrophy
 Paralysis Parkinson's Disease Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**9. Reproductive System/
Urinary System**
 Yes No

Abnormal Pap Smear (Last three Pap Readings (Ex. normal 03 / 13 / 04))
 1. _____ / _____ / _____ 2. _____ / _____ / _____ 3. _____ / _____ / _____
 Bladder Disorder (specify) _____ Breast Disorder (specify) _____
 Endometriosis/Adhesions Infertility Kidney Stones Kidney Disorder (specify) _____
 Pregnant (due date ____/____/____) Current Pregnancy Complications
 Prostate Disorder (specify) _____ Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

10. Respiratory System
 Yes No

Allergies Asthma Chronic Sinusitis Emphysema Chronic Bronchitis Pneumonia
 Shortness of Breath Sleep Apnea Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

11. Transplant
 Yes No

Organ (type(s)) _____ Bone Marrow
 Surgery Advised or Pending Yes No Surgery Completed Yes No Date Completed _____
 Other (specify) _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**12. Tumor/Cancer/Polyps/
Cyst**
 Yes No

Brain Breast Colon Hodgkin's Disease Leukemia/Lymphoma Lung Melanoma
 Pancreatic Polyps (specify type) _____ Prostate Sarcoma Testicular Other (specify) _____
 Patient Name's _____ Date Diagnosed _____
 Stage/Level _____ Malignant Benign
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

**13. Symptoms, Conditions
or Treatment not listed
above**
 Yes No

Abnormal Lab, Test or Physical Exam Results Pain, Discomfort or Abnormality Not Yet Seen by a Physician
 Treatment or Surgery Advised But Not Yet Done Condition _____
 Patient's Name _____
 Diagnosis/Treatment/Medication _____
 Current Status _____ Date Diagnosed _____
 Date of Last Doctor Visit _____ Doctor's Name/Phone _____

14. Current Medication <input type="checkbox"/> Yes <input type="checkbox"/> No	Medication _____	Medication _____	Medication _____
	Patient's Name _____	Patient's Name _____	Patient's Name _____
	Diagnosis _____	Diagnosis _____	Diagnosis _____

I hereby agree that the answer to each of the above questions is complete and true, that such answers have been fully and correctly recorded, and that no material information concerning the person's past or present health has been omitted. I agree that such answers will form part of my application for group insurance, and that such insurance will not become effective until such application has been approved by Blue Cross and Blue Shield of South Carolina and/or Companion Life Insurance Company.

PRINT NAME _____

SIGNATURE _____ DATE _____