

Health Addendum to Employee Enrollment form for Association Health Plans



Ohio

Enrollee Name: _____ SSN: _____

Medical History

Please answer completely and truthfully. Please note that if you leave out or misrepresent information, we may terminate or not renew your coverage, or we may change your premium retroactive to the date your policy became effective. All statements contained in this entire form must be true and correct and no material information can be withheld or omitted.

United Healthcare Services, Inc. is only seeking to collect information about the current health status of those persons listed on the application. In answering these questions, you should not include any genetic information. Please do not include any family medical history information or any information related to genetic services or genetic diseases for which you believe you or your dependents may be at risk.

Has anyone on this enrollment form been diagnosed, consulted with, or been examined or treated by any health care professional during the last 5 years for any illness, injury, or health condition in any of the categories listed below? If yes, please check the box that most appropriately describes the problem and explain fully below.

1 Cancer/Tumor <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Breast <input type="checkbox"/> Colon <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Melanoma <input type="checkbox"/> Testicular <input type="checkbox"/> Brain <input type="checkbox"/> Ovarian <input type="checkbox"/> Cervical <input type="checkbox"/> Prostate <input type="checkbox"/> Other Cancer <input type="checkbox"/> Non-Malignant Tumor – Location of Tumor _____
2 Heart / Circulatory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Aneurysm <input type="checkbox"/> Bypass <input type="checkbox"/> Angioplasty/Stent <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Elevated Cholesterol/Triglycerides <input type="checkbox"/> Heart Disease <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Stroke <input type="checkbox"/> Angina <input type="checkbox"/> Hemophilia <input type="checkbox"/> Blood Clots <input type="checkbox"/> Pacemaker/ICD <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Sickle Cell Anemia <input type="checkbox"/> Other _____
3 Reproductive <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Pregnancy (due date _____ if multiples #____) <input type="checkbox"/> Pregnancy Complications <input type="checkbox"/> Fibroids <input type="checkbox"/> Menstrual Disorders <input type="checkbox"/> Breast Disorders <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Other _____
4 Intestinal / Endocrine <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Chronic Pancreatitis <input type="checkbox"/> Colon Disorder <input type="checkbox"/> Crohn's <input type="checkbox"/> Ulcerative Colitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatitis B/C <input type="checkbox"/> Reflux <input type="checkbox"/> Liver Disorder <input type="checkbox"/> Ulcer <input type="checkbox"/> Growth Hormones <input type="checkbox"/> Gallbladder <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Other _____
5 Brain/Nervous <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alzheimer's Disease <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Migraines <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Paralysis <input type="checkbox"/> Seizures/Epilepsy <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Head Injury <input type="checkbox"/> Cyst <input type="checkbox"/> Other _____
6 Immune <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Scleroderma <input type="checkbox"/> ALS <input type="checkbox"/> Psoriasis <input type="checkbox"/> AIDS <input type="checkbox"/> HIV+ <input type="checkbox"/> Lupus <input type="checkbox"/> Immuno Deficiency <input type="checkbox"/> Other _____
7 Lung/Respiratory <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Allergies <input type="checkbox"/> Asthma <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Lung Disorders <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Sleep Apnea <input type="checkbox"/> Chronic Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other _____
8 Eyes/Ears/Nose/Throat <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Acoustic Neuroma <input type="checkbox"/> Cataracts <input type="checkbox"/> Cleft Lip/Palate <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Glaucoma <input type="checkbox"/> Retinopathy <input type="checkbox"/> Chronic Ear Infections <input type="checkbox"/> Chronic Sinusitis <input type="checkbox"/> Other _____
9 Urinary/Kidney <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Disorders <input type="checkbox"/> Bladder Disorders <input type="checkbox"/> Polycystic Kidney Disease <input type="checkbox"/> Prostate Disorder <input type="checkbox"/> Renal Failure <input type="checkbox"/> Other _____
10 Bones/Muscles <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Bulging/Herniated Disc <input type="checkbox"/> Joint injury <input type="checkbox"/> Fibromyalgia/Chronic Fatigue Syndrome <input type="checkbox"/> Chronic Pain Syndrome <input type="checkbox"/> Shoulder Disorder <input type="checkbox"/> Knee Disorder <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Back Disorder <input type="checkbox"/> Neck Disorder <input type="checkbox"/> Other _____
11 Behavioral Health <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anxiety/Depression <input type="checkbox"/> ADHD <input type="checkbox"/> Bipolar Depression <input type="checkbox"/> Manic Depression <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Autism <input type="checkbox"/> Eating Disorder <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Inpatient Alcohol/Drug <input type="checkbox"/> Inpatient Mental Health Hospital <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other _____
12 Transplant <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Bone Marrow <input type="checkbox"/> Organ <input type="checkbox"/> Discussed Possible Future Transplant <input type="checkbox"/> Stem Cell <input type="checkbox"/> Transplant Complications <input type="checkbox"/> Other _____
13 Other <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Condition not mentioned above with claims in excess of \$5,000 <input type="checkbox"/> Disability <input type="checkbox"/> Congenital Disorder
14 Tobacco <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anyone on this enrollment form used tobacco products in the past 12 months: Person _____
15 Medications <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Current Medications: Person _____ # of Meds _____ Person _____ # of Meds _____ (list meds below) <input type="checkbox"/> Medications taken within the past 12 months: Person _____ # of Meds _____ Person _____ # of Meds _____ (list meds below)

