Employee Health Evaluation Form

Innovative Stop Loss Solutions

Employer Information INSTRUCTION: THIS FORM IS TO BE COMPLETED BY THE EMPLOYEE

Employer Name:	Date of Hire:	Effective Date of Coverage:

Employee Information

Last name	First Name	Middle Initial	Date of Birth	Gender

Plan Selection (if applicable):

If waiving coverage, check here: Waiving coverage Otherwise complete the below Yes ☐ No ☐

If Applying for Dependent Coverage, Complete Section Below for all Dependents to be Covered:

(Common Law spouses are NOT eligible for coverage, unless required by law. Use additional paper if necessary.

	First Name & Middle Initial	**Last Name** *(if different from applicant)*	**Step-Child**	**Gender**	**Date of Birth**
Sp					
Ch1					
Ch2					
Ch3					
Ch4					

Medical Information

To the best of your knowledge, answer the following questions for yourself and all dependents you are enrolling. The information on this form is designed to assist in the Insurance Carrier's evaluation of your group.

In the past three (3) years has any person enrolling consulted a health care provider, received treatment (including prescription medications), or been hospitalized for any of the following conditions, disorders, or diseases?

		Yes	**No**
1.	**Heart and Circulatory Disorders** (including heart attack, murmur or surgery; stroke, high blood pressure or high cholesterol); **Brain and Nervous System Disorders** (seizures, paralysis, multiple sclerosis, migraine headaches, depression/anxiety); **Cancer/Tumors; Endocrine Disorders** (diabetes, lupus, chronic fatigue, thyroid disorders, immune disorders, AIDS/ARC); **Respiratory Conditions** (including asthma, emphysema or pneumonia); **Intestinal/Digestive Disorders** (GERD, liver diseases, colitis, hernia, *hepatitis or gall bladder disorders*); **Musculoskeletal Disorders** (herniated disks, neck/back strains, joint replacement, arthritis, knee or shoulder injury, carpal tunnel); **Congenital Disorders** (heart defects, cleft palate, Down's Syndrome); **Kidney Disorders** (kidney failure, dialysis, kidney stones); or **Skin Disorders** (psoriasis, basal cell or melanoma type cancer)?	☐	☐
2.	Are you or any dependent currently **pregnant** or undergoing **fertility treatment**; or an organ or tissue **transplant** donor, recipient or *candidate*?	☐	☐
3.	Have you or any dependent been hospitalized in the past 12 months or advised that you will need to be hospitalized or receive surgery?	☐	☐
4.	Are you or any dependent currently receiving any infusion treatment?	☐	☐

For any "Yes" answers provided in the above section, list the details for each "yes" answer in the section below. Use additional paper if necessary.

Question No.	EE/SP/ CH(#)	Age	Condition/Disorder	Type of Treatment	Medications	Begin Date	End Date

Signature (This form must be signed and dated)

I, the Applicant, understand, to the best of my knowledge, the information provided on this Individual Risk Evaluation Form is complete and accurate. I, the Applicant, understand that if I have misstated or omitted any information on this form, Innovative Stop Loss Solutions may reassess premium applied to my employer group and/or me, deny claims, or terminate Innovative Stop Loss Solutions coverage in accordance with applicable law. Innovative Stop Loss Solutions, its reinsurers, and their authorized representatives are authorized to obtain medical information in order to evaluate the information contained in this Employee Health Evaluation Form.

Applicant Signature: _____ Date: _____