## Employee Health Evaluation Form



In playee Information Last name   First Name   First Name   Middle Initial   Date of Birth   Gender	, -,	r <b>mation</b> me:			114011100		1 (10)	Date of Hire:			Coverage:
Plan Selection (if applicable):											
Plan Selection (if applicable):  If waiving coverage, check here:  Otherwise complete the below  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   Last Name   Child   Birth	mployee Info	rmation				=		,			
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& Middle Initial (if different from applicant)  Sp							Ullai	рары п пьсьзану	<b>/</b> .		
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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   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, collitis, hernia, hepatitis or gall bladder disorders); Musculoskeletal 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 EE/SP/ Age Condition/Disorder Type of Treatment Medications Begin End Date Date in Applicant, understand, to the best of my knowledge, the information provided on this Individual Risk Evaluation Form is			•			-					
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authorized to obtain medical information in order to evaluate the information contained in this Employee Health Evaluation Form.

Date:

Applicant Signature: \_\_\_\_\_\_\_