OREGON STANDARD HEALTH STATEMENT

(Standard Form per ORS 743.766)

PART A:
[Insert carrier's logo/information here; format may vary, but may not include questions relating to health-risk status, such as occupation, hobbies, etc.]

You are not required to disclose any information on any part of this application about genetic testing or genetic information relating to you or to any blood relative. You are not required to disclose any decision by an insurance company that is based on a genetic test or on genetic information. A person under the age of 19 applying for an individual health benefit plan may not be denied enrollment or excluded from coverage due to health reasons.

Name: _____

Residence address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Work phone: _____ County: _____

Billing address (if different from residence address):

_____ City: _____ State: _____ ZIP: _____

Do you or any family members have other active health or medical coverage, Medicare, Medicare Advantage, or Medicare supplement coverage? ☐ Yes ☐ No

If yes, name of insurance company: _____

Effective date of current medical coverage: _____

Termination date of current medical coverage: _____

Do you or any family member work for an employer who offers health benefits to employees?
☐ Yes ☐ No

Are you or any family members enrolled? ☐ Yes ☐ No

If no, why? _____

_____

_____

_____

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PART B: [Cannot include other health questions or questions relating to health-risk status, such as occupation, hobbies, etc., and cannot include questions concerning genetic testing of or genetic information about the applicant or any blood relative of the applicant.]

Has any insurance company within the past five years declined, postponed, refused, restricted, or increased the premium for health reasons for life or health insurance coverage for anyone listed on this application?

☐ Yes ☐ No

If yes, name of person affected, reason for action, and name of insurance company:

_____

_____

_____

[Insert insurance carrier's name] may review its claims history for the past five years for anyone who has had insurance with [insert insurance carrier's name] during that time. List the names and [insert insurance carrier's name] identification numbers of anyone on this application who has had insurance with [insert insurance carrier's name] during the past five years.

Provide the following information for each person to be covered:

	Last name of family member	First name, middle initial	Height	Weight	Sex	Date of birth	Social Security number
Subscriber							
Spouse							
Child							
Child							
Child							
Child							
Child							
Child							

Explain the relationship to the subscriber for any person listed above whose last name is different from the subscriber's: _____

_____

_____

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Please mark "Yes" or "No" for each item (for you and any family members). Provide details on Page 6 to any questions answered "Yes." (**For the purpose of these questions, *chronic* means persistent, continuous, or periodic, or a combination of any of these terms.**)

Within the past five years, has anyone listed on this application had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of the following conditions:

1. AIDS, ARC, HIV positive ☐ Yes ☐ No
2. Alcohol/chemical/drug abuse/habit ☐ Yes ☐ No
3. Anemia/chronic fatigue ☐ Yes ☐ No
4. Appendicitis/chronic abdominal pain ☐ Yes ☐ No
5. Back/neck/spine ☐ Yes ☐ No
6. Birth defect/congenital deformities ☐ Yes ☐ No
7. Bladder/urinary tract ☐ Yes ☐ No
8. Blood/circulatory ☐ Yes ☐ No
9. Bone/orthopedic ☐ Yes ☐ No
10. Brain disease or injury/concussion ☐ Yes ☐ No
11. Breast (lumps or masses) ☐ Yes ☐ No
12. Cancer ☐ Yes ☐ No
13. Chemotherapy/radiation treatment ☐ Yes ☐ No
14. a. Colon/rectum/intestine/bowel ☐ Yes ☐ No
    b. Blood in stool ☐ Yes ☐ No
15. Convulsion/seizures/epilepsy ☐ Yes ☐ No
16. Diabetes/sugar in urine ☐ Yes ☐ No
17. Chronic ear/nose/throat/tonsil condition/disease/disorder ☐ Yes ☐ No
18. Eating disorders such as, but not limited to, anorexia or bulimia ☐ Yes ☐ No
19. Emphysema/asthma/chronic lung disease (COPD) ☐ Yes ☐ No
20. Endocrine/gland/hormone system ☐ Yes ☐ No
21. Disease or injury of eye/ cataract/glaucoma ☐ Yes ☐ No
22. Gallbladder/pancreatic disease ☐ Yes ☐ No
23. Chronic headaches/migraines ☐ Yes ☐ No
24. Heart/chest pain/angina ☐ Yes ☐ No
25. Hernia ☐ Yes ☐ No
26. High cholesterol (if "Yes," record last reading on page 6) ☐ Yes ☐ No
27. High blood pressure (if "Yes," record last reading on page 6) ☐ Yes ☐ No
28. Kidney/kidney stones ☐ Yes ☐ No
29. Knee/shoulder/hip/other joints ☐ Yes ☐ No
30. Liver condition/hepatitis ☐ Yes ☐ No
31. Lupus, chronic muscle pain, muscle injury or disease, or fibromyalgia ☐ Yes ☐ No
32. a. Mental/emotional condition/depression ☐ Yes ☐ No
    b. Therapy/counseling within last 5 years (if "Yes," record date of last session on page 6) ☐ Yes ☐ No
33. Neurological condition/disease/injury ☐ Yes ☐ No
34. Phlebitis/blood clot ☐ Yes ☐ No
35. Osteoarthritis/osteoporosis/osteopenia ☐ Yes ☐ No
36. Prostate/elevated PSA/prostatitis ☐ Yes ☐ No
37. Reproductive system disorder/infertility ☐ Yes ☐ No
38. Chronic respiratory/lung condition ☐ Yes ☐ No
39. Rheumatoid arthritis ☐ Yes ☐ No
40. Sexually transmitted disease(s) ☐ Yes ☐ No
41. Skin condition, abnormal or cancerous moles or eczema/cysts/cancer ☐ Yes ☐ No
    ☐ Yes ☐ No
42. Sleep apnea/chronic sleep disorder ☐ Yes ☐ No
43. Stomach disorders/ulcer/acid reflux ☐ Yes ☐ No
44. Stroke/paralysis/seizures ☐ Yes ☐ No
45. Tumors ☐ Yes ☐ No
46. TMJ/jaw joint ☐ Yes ☐ No
47. Weight fluctuation (+/-20 lbs.) ☐ Yes ☐ No
48. Cosmetic surgery/implants, use of prosthetic devices/limbs ☐ Yes ☐ No

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49. Has any person on this application used tobacco products in any form within the past five years?
☐ Yes ☐ No. If yes:

Name: _____ Type of product: _____

Name: _____ Type of product: _____

Name: _____ Type of product: _____

50. Please provide the following information for each **female** on this application:

Family member	Name:	Name:	Name:	Name:
a. Initial menstrual cycle begun?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Date of last menstrual period?				
c. If (b) is more than 35 days ago, please explain:				
d. Excessive or absent menstrual bleeding?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
e. If (d) is yes, please explain:				
Date of last DEPO Provera shot?				
Abnormal Pap smears?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Prior Cesarean section or miscarriage?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

51. Is any person on this application now pregnant? ☐ Yes ☐ No

If yes, name: _____ Due date: / /

52. Is any person on this application, including male applicants and dependent males or females, responsible for a current pregnancy? ☐ Yes ☐ No

If yes, name: _____ Due date: / /

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(Standard Form per ORS 743.766)

53. Please provide the following information for each person on this application. Within the past five years, has any person on this application:
    a. Had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement not listed above? ☐ Yes ☐ No
    b. Had chronic cough, fatigue, diarrhea, or enlarged glands? ☐ Yes ☐ No
    c. Been advised to have or contemplated having an operation or medical procedure not yet performed? ☐ Yes ☐ No
    d. Been scheduled to see a health care provider? ☐ Yes ☐ No
    e. Taken any prescription medication on a regular basis? ☐ Yes ☐ No

54. List all medications currently being taken by any person on this application:

Name	Medications (frequency & dosage REQUIRED)	Prescribed by (name/address/phone)	Date prescribed

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Provide specific details below to each question answered "yes" on pages 3 through 5. Include insured/applicant's name; the number of the question to which you answered "yes"; the condition, treatment, and date; the result of treatment, including any medications; and the name, address, and phone number of the attending physician, other health care provider, or clinic/hospital.

Provide details below to any questions answered "YES" on the previous page.

HEALTH HISTORY DETAILS						
Name	Question number	Start to end dates	Condition	Treatment **including medications**	Final result **ongoing or resolved**	Attending physician/health care provider or hospital (name/address/phone)
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	
					☐ **O** ☐ **R**	

Attach additional pages, if necessary. I have attached __ page(s).

Name, address, and phone number of medical provider who holds current medical records/history

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ ZIP: _____

OREGON STANDARD HEALTH STATEMENT

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Be sure to sign and date the application. Spouse's signature is required if married. Signature applies to both "Certificate of Completeness and Correctness" and "Authorization for Release of Information."

CERTIFICATION OF COMPLETION AND CORRECTNESS

I affirm that the answers given in this "Oregon Standard Health Statement" are complete and correct. I have provided these answers as part of the application procedure required by this insurance carrier to enroll in its insurance coverage. I understand that if this application contains any intentional misrepresentations of material fact, [Insert insurance carrier's name] may, within the first two years of coverage, deny coverage, modify or cancel the contract, or take other legal action. I further understand that if the misrepresentation amounts to fraud, [insert insurance carrier's name] may deny coverage, modify or cancel the contract, or take other legal action even after the first two years of coverage. I will promptly inform [insert insurance carrier's name] in writing if anything happens before my coverage takes effect that makes the information I have provided on this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by [insert insurance carrier's name]. If approved, coverage will be in force as of the effective date determined by [insert insurance carrier's name]. [Insert insurance carrier's name] may contact me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

Signature or applicant or applicant's representative	(Signature or spouse or spouse's representative, if applicable)

CONDITIONAL AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION [**:** An insurer shall insert here and use the conditional authorization statement, along with signature lines, that the insurer normally uses to comply with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191) (HIPAA). An insurer may also include a conditional authorization signature provision that allows a parent to sign for a dependent older than 18 when that action is allowed under HIPAA.]