NetCare
Life & Health Insurance

HEALTH STATEMENT

The following information is requested regarding your health and the health of any member of your family for whom you wish to obtain health coverage through NetCare. Please list all names below. Attach additional sheets if necessary. Any misrepresentation of pre-existing impairments, conditions or diseases will void your coverage.

FAMILY MEMBER NAME	SEX	DATE OF BIRTH	WEIGHT	HEIGHT	SS#

*If applicant or any family member received care under another name, please list other name.

Section A All questions must be marked Yes or No. If 'Yes', circle the applicable condition(s) and provide details in Section B.

1. Have you or any applying family member ever received any professional medical advice or treatment for, or had any symptoms pertaining to any of the following conditions?	**YES**	**NO**
1a. Brain or Nervous System: such as dizziness, fainting, headaches, shortness of breath, seizure disorder, epilepsy, paralysis, aneurysm, muscular dystrophy, multiple sclerosis, stroke, cerebral palsy, polio or others?	☐	☐
1b. Heart or Cardiovascular System: such as heart disease, chest pain, high or abnormal blood pressure, heart valve problems, heart attack, heart murmur, rheumatic fever, palpitations, or others?	☐	☐
1c. Circulatory System: such as varicose veins, peripheral vascular disease, phlebitis, blood clots, bleeding problems, blood disorder, anemia or enlarged lymph glands, or others?	☐	☐
1d. Lungs or Respiratory System: such as asthma, reactive airway disease, bronchitis, hay fever, allergies, sinusitis, emphysema, tuberculosis, cycstic fibrosis, chronic obstructive pulmonary disease, breathing difficulty or others?	☐	☐
1e. Digestive System: such as mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, hepatitis, pancreatitis, colon, intestinal or rectal problems, bleeding, polyp, hemorrhoids, hernia, or others?	☐	☐
1f. Urinary Tract: such as kidney, ureter, bladder, urethral problems, infections, stricture, stones, or others?	☐	☐
1g. Male Reproductive System: such as prostate problems, infertility, impotence, male breast problems, gynecomastia, syphilis, gonorrhea or other venereal disease, or others?	☐	☐
1h. Female Reproductive System: such as breast problems, breast implants, abnormal bleeding, amenorrhea, endometriosis, fibroid tumors, abnormal Pap test, problem of the ovaries and/or uterus, infertility, in-vetro fertilization, genital warts, syphilis or other venereal disease, or others?	☐	☐
1i. Musculo-Skeletal System: such as neck, spine/back sprain, pain, injury, sciatica, herniated or bulging discs, abnormal curvature of the spine, scoliosis, any problems of the joints, bones, muscle or tendons, arthritis, fractures/residual hardware, dislocation, carpal tunnel syndrome, physically handicapped, amputation, or others?	☐	☐
1j. Metabolic System: such as diabetes, gout, goiter, thyroid, parathyroid or adrenal disorder, growth hormone deficiencies or immune system disorders such as; lupus, raynauds, acquired immune deficiency syndrome (AIDS), or any other blood disorder, including evaluation for AZT therapy, or others?	☐	☐

	YES	NO
2. Have you or any applying family member ever had a history of or incidence of the following?		
2a. Skin Conditions: such as skin cancer, melanoma, psoriasis, warts, birthmarks, burns, severe acne, dermatitis, eczema or others?	☐	☐
2a. Diseases or problems of the eyes, ears, hearing, nose or throat: such as glaucoma, cataract, crossed eye, detached retina, nasal polyps, deviated nasal septum, ear infections, problems with tonsils or adenoids, sleep apnea, or others?	☐	☐
2c. Cancer, tumor(s), cyst(s), Leukemia, Hodkins Disease, lymphoma, or others?	☐	☐
2d. Alcoholism, drug dependency or substance abuse?	☐	☐
2e. Tobacco dependency? (Do you or any applying family member smoke cigarettes?)	☐	☐
2f. Congenital abnormalities, birth defects, such as; heart defects, Down's Syndrome, cleft lip or palate, club foot, developmental delay, mental retardation or other neurological or physical abnormalities, or others?	☐	☐
3. Have you or any applying family member received any counseling, professional advice or treatment for: symptoms of depression, anxiety, panic attacks, nervousness, mental or emotional disorder, schizophrenia, behavioral problems, attention deficit disorder, or for any other reason?	☐	☐
4. Have you or any applying family member ever had surgery of any kind including: Cosmetic/reconstructive procedure/surgery (including breast implants), or organ transplant surgery?	☐	☐
5. Have you or any applying family member ever had: Abnormal laboratory results, blood work, x-ray, EKG, treadmill stress test, nerve conditions, MRI scan, CT scan, ultrasound, or endoscopic procedures?	☐	☐
6. Do you or any applying family member have a prosthesis, implants, or retained hardware?	☐	☐
7. FOR FEMALE APPLICANTS ONLY (Subscriber, spouse, dependent) Please answer all questions below:		
7a. Do you or any of your applying family members have a history of ectopic pregnancy, pregnancy with complications (e.g. gestational diabetes, pre-eclampsia/eclampsia) or miscarriage?	☐	☐
7b. As far as you know, are you or any applying female family member now pregnant?	☐	☐
7c. If pregnant, when is the expected delivery date? Date: _____		
7d. If not pregnant, when was your last menstrual period: Date: _____		
7e. Have you or any applying family member ever had a pregnancy resulting in cesarian section, or is one anticipated?	☐	☐

Section B: If you have answered 'Yes' to any of the questions in Section A, please give full details below, including the Question number. If additional space is necessary to provide complete information, please attach an additional sheet of paper. Mark here ☐ if there is an attachment.

QUESTION NO.	NAME OF FAMILY MEMBER	DIAGNOSIS	DATE OF TREATMENT(S)	FULL NAME OF PHYSICIAN CLINIC/HOSPITAL

Section C For yourself and each applying family member, please list the details of visits to a physician, clinic or hospital in the last 5 years, for any reason, including a check -- up or physical exam.

NAME OF FAMILY MEMBER	DATE OF VISIT	REASON FOR EXAMINATION/CHECK-UP	FINDINGS AND PRESENT STATUS	FULL NAME OF PHYSICIAN CLINIC/HOSPITAL

Section D Are you or any applying family member currently taking any medication or have you taken any medication in the past 12 months? If "Yes", please list below.

YES	NO

NAME OF FAMILY MEMBER	NAME OF MEDICATION AND CONDITION FOR WHICH MEDICATION WAS PRESCRIBED	DATE FROM/TO	FULL NAME OF PHYSICIAN

Section E Please answer each question. If "Yes", please provided details in the space provided.

8. Are you or any applying family member disabled, hospitalized or receiving medical care in the home at this time?

YES	NO

Family Members(s):
Please Explain:

9. Have you or any applying family member been advised to undergo further testing, treatment, organ transplant or surgery which has not yet been performed by a physician, dentist, or other provider?

YES	NO

Family Members(s):
Please Explain:

10. Do you or any applying family member presently have any condition or illness not mentioned previously, or complications or residuals (prosthesis, implants, or retained hardware) remaining following any treatment?

YES	NO

Family Members(s):
Please Explain:

11. Have you or any applying family member ever had any application for health or life insurance declined, postponed or restricted in any way?

YES	NO

Family Members(s):
Please Explain:

12. Are you or any of your eligible dependents currently covered, or had coverage with another health care plan in the last 90 days? If yes, Group ☐ or Individual ☐ (check one)

YES	NO

Family member: _____

Insurance company or plan: _____

AUTHORIZATION

I authorize any physician, practitioner, hospital, medical care institution, insurance company or other organization, person or employer that has any records or knowledge of care, treatment or advice of myself, my spouse or my children to release such information to NetCare or it's representative. This authorization remains in effect as long as necessary to evaluate my application and/or process claims for me and my covered dependent(s). A photographic copy of this authorization shall be valid as the original.

AGREEMENT

I understand that NetCare has the right to reject my application and if so, I will be notified in writing, and that NetCare is not obligated to disclose the reason for refusal.

I understand and agree that if NetCare rejects my application, under no circumstance will any benefits be payable for any person listed on this application.

I understand that by signing this Health Statement and returning it to NetCare, I am applying for health benefits for myself and all of my family members who are listed in this Health Statement.

If any condition, disease or change in health status occurs after you complete this Health Statement, but before the effective date, you must immediately update this Application by submitting a written explanation to **NetCare Health Plans.** If you fail to provide this updated information, or if you provide any incorrect or incomplete answers on this Health Statement or in future correspondence concerning this Health Statement, your coverage and your family's coverage may be terminated at any time.

Coverage will begin the first of the month following submission of the application unless notification is given by **NetCare** to change the effective date.

All applicants 18 and over must sign below.

SIGNATURE OF APPLICANT OR LEGAL GUARDIAN	PRINT NAME	DATE
SIGNATURE OF APPLICANT'S SPOUSE(IF APPLYING)	PRINT NAME	DATE
SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER(IF APPLYING)	PRINT NAME	DATE
SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER(IF APPLYING)	PRINT NAME	DATE
SIGNATURE OF FAMILY MEMBER AGE 18 AND OVER(IF APPLYING)	PRINT NAME	DATE