UNIVERSAL MEDICAL APPRAISAL FORM

GROUP NAME:____

This form must be completed by each employee applying for coverage and must include All dependent(s).

APPLICANT INFORMATION- for enrolling coverage(s) only

	Name	M/F	Soc. Sec. #	Zip Code	Date of Birth	Height	Weight
Employee:							

Dependent Information:

	Name	M/F	Soc. Sec. #	Date of Birth	Height	Weight
Spouse:						
Child:						
Child:						
Child:						
Child:						
Child:						
Child:						

LEVEL OF BENEFITS APPLIED FOR:

_____**Employee Only** _____**Employee & Child** _____**Employee & Spouse** _____**Employee & Child(ren)** _____**Family**

WAIVER OF COVERAGE:

Complete this section if you wish to decline coverage offered for you and/or your family member(s)

For: _____Myself _____My Spouse _____ My Dependent Children _____Myself & all Family Members

Employee Signature: ____ **Date:**____________________

REASON FOR WAIVER:

___ Employer Waiting Period
___ Insured on Spouse's Plan
___ Other ____________________

MEDICAL INFORMATION:

Have you or your dependents listed above EVER had any signs or symptoms, or been told to have, or been treated or diagnosed with a condition for which consultation was or will be sought for any of the conditions listed below?

Circle "yes" or "no" to all questions: Give details for all answered "yes" in the explanation section and indicate the referral number. Include for whom (ex: self, spouse, etc), diagnosis, date of diagnosis, date of last treatment; indicate severity as well as any medications taken and dosage. If surgery is needed, please indicate reasoning and pending dates, etc.

Please circle all that apply:

Condition	Y	N
1. Benign Conditions -Tumor, Cyst or Growth	Y	N
If Yes, list Site ______________________		
2. Cancers - List status in Explanation Section	Y	N
If Yes, list Site _______________________		
3. Heart/Lung		
Aneurysm	Y	N
Arteriosclerosis	Y	N
Chest Pain/Angina	Y	N
Congenital Heart Disease	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
High Cholesterol/Triglycerides	Y	N
Hypertension	Y	N
Irregular Heart Beat	Y	N
Ischemic Heart Disease	Y	N
Stroke	Y	N
Valvular Disease	Y	N
Apnea	Y	N
Asthma/Allergy	Y	N
Cystic Fibrosis	Y	N
Emphysema/COPD	Y	N
Tuberculosis	Y	N
4. Heart/Lung Treatments		
Angioplasty	Y	N
Bypass	Y	N
Cardiac Ablation	Y	N
Cardiac Catherization	Y	N
Pacemaker Implantation	Y	N
Heart Valve Replacement	Y	N
5. Blood Disorders		
Anemia - Type _____________________	Y	N
Hemochromatosis	Y	N
Hemophilia	Y	N
Other - Type ________________________	Y	N
6. Renal		
Blood in Urine	Y	N
Dialysis	Y	N
Kidney, Kidney Stones, Urinary Disorder	Y	N
Polycystic Kidney Disease	Y	N
Renal Failure - Acute _____ Chronic _____	Y	N

Condition	Y	N
7. Immune		
AIDS/ARC-AIDS Related Complex/HIV	Y	N
Autoimmune Illness-Type ________________	Y	N
Systemic Lupus	Y	N
8. Endocrine		
Diabetes - Juvenile ______ Adult _______	Y	N
Diet Controlled ____ Oral Meds _____		
Insulin ______ Units per day _______		
Last Three (3) Blood Sugar Readings		
_________ _________ _________		
Last Hemoglobin A1-C (Hb A1-C) Result ______		
Date of Last Hb A1-C: ______/______/______		
Growth Hormone	Y	N
Pancreatitis	Y	N
Pituitary Disorder	Y	N
Thyroid/Adrenal Disorder	Y	N
9. Digestive/Intestinal		
Cirrhosis of Liver	Y	N
Colonoscopy	Y	N
Colostomy	Y	N
Crohn's Disease	Y	N
Gastric Bypass	Y	N
GERD/Peptic Ulcer	Y	N
Hepatitis Type - A _____ B _____ C _____	Y	N
Ulcerative Colitis	Y	N
10. Neurological		
Alzheimer's	Y	N
Cerebral Palsy	Y	N
Down's Syndrome	Y	N
Epilepsy/Seizures	Y	N
Grand Mal	Y	N
Petit Mal	Y	N
Lou Gehrig's Disease (ALS)	Y	N
Migraines	Y	N
Multiple Sclerosis	Y	N
Paralysis	Y	N
Parkinson's Disease	Y	N
Spina Bifida-Cystica______Occulta______	Y	N

Condition	Y	N
11. Psychological		
Active Counseling	Y	N
ADD/ADHD	Y	N
Anxiety, Depression	Y	N
Attempted Suicide	Y	N
Bulimia, Anorexia	Y	N
Psychosis	Y	N
Schizophrenia, Bipolar, OCD	Y	N
Substance Abuse	Y	N
Any Mental Health Hospitalization	Y	N
12. Muscular/Skeletal		
Amputation-Of___________________	Y	N
Arthritis-Rheumatoid_____Osteo______	Y	N
Degenerative Disc/Joint Disease	Y	N
Fibromyalgia	Y	N
Gout	Y	N
Herniated Disc	Y	N
Joint Replacement- Of _____________	Y	N
Muscular Dystrophy	Y	N
Osteoporosis	Y	N
Scoliosis	Y	N
13. Reproductive		
Abnormal Pap Smear	Y	N
Date of Last Normal Pap Smear: ___/___/____		
Breast Disorder or Breast Implants	Y	N
Endometriosis	Y	N
Infertility-If Yes:	Y	N
Type of treatment _____________		
Invitro_________ GIFT_________		
Other Reproductive	Y	N
Ovarian Cyst/PCOS	Y	N
Prostatitis/BPH	Y	N
Sexually Transmitted Disease(s)	Y	N
Pregnant-Due Date ____/____/______	Y	N
If pregnant: Do you have or ever had:		
Gestational Diabetes	Y	N
Hypertension	Y	N
Incompetent Cervix	Y	N
Multiple Birth Pregnancy	Y	N
Prior Miscarriage	Y	N
Pre Term Labor or Premature Birth(s)	Y	N

		Y	N
14.	Do you or any of your dependents have any other medical conditions not listed on questions #1 thru #13 that have been diagnosed or treated by a health care provider in the past 5 years?	**Y**	**N**
15.	Do you or any of you dependents currently use tobacco products?	**Y**	**N**
16.	Have you or any of your covered dependents ever had or been advised to have an organ or bone marrow transplant?	**Y**	**N**
17.	Have you or any of your dependents been hospitalized or had surgery within the past 5 years?	**Y**	**N**
18.	Have you or any of your dependents been advised to have surgery which has not been performed yet?	**Y**	**N**
19.	Are you or any of your dependents currently taking prescription medications that have not already been listed? If yes, please list patient's name, name of medication(s), dosage and reason for taking it.	**Y**	**N**
20.	If you have been hired in the last six months, have you or any of your dependents been treated by a health care provider six months prior to your hire date?	**Y**	**N**
21.	Have you or any of your dependents ever been eligible for benefits from Workers' Compensation, Disability, or Subrogation for any of the conditions listed in the medical section above?	**Y**	**N**

If any of the previous questions #1 thru #21 were answered "yes" please provide details below.

Question #	Patient Name	Hospitalization Date (s)	Treatment Dates From/To		Diagnosis, Treatment, Prognosis, and Medications/Dosages

Additional Information:

I have read the entire Application and by signing this form, I declare that all information, statements and answers are true and complete for all listed individuals applying for coverage. I also understand under WV Code §33-41-3, "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Employee Signature: ____ **Date:**_____________