Employee Health Application Form

carepath BENEFITS

Section 1: Employer Information

Employer Name: **State Security Agency** Hire Date: Location/Division:

Employer Address: **70-21 Austin St., 3rd Floor**

City: **Forest Hills** State: **NY** Zip: **11375**

Section 2: Employee Information

Employee Name: Social Sec #: Date of Birth:

Address: Job Title:

City: State: Zip:

Marital Status: ◯ Single ◯ Divorced ◯ Married ◯ Widowed

Home Phone: ( ) Cell Phone: ( ) E-mail Address:

Hours Worked per Week:

Spouse's Employer: Spouse's Business Phone: ( )

Section 3: Other Insurance Coverage

Do you or your spouse have other health insurance? ☐ YES ☐ NO If YES, name of Carrier:

Policy Holder's Name: Policy #: Effective Date:

Name of Covered Dependents:

Section 4: Subscriber / Dependents (Please complete for employee subscriber and all participating dependents.)

Name First Last	**Relationship** (Spouse, Child)	**M / F**	**DOB**	**Social Sec. #**	**Height**	**Weight**	**Tobacco Use** (Y/N)
	Employee						

Section 5: Health Plan Participation

◉ I elect to participate

◯ I decline participation

Coverage Level (Choose 1)

◯ Employee Only

◯ Employee / Spouse

◯ Employee / Child(ren)

◯ Family

Plan Selection (Please write-in below)

MEC _____

Reason for decline:

◯ Spouse's Employer's Plan ◯ Individual Plan ◯ Medicare ◯ Medicaid ◯ COBRA from Prior Employer

◯ VA Eligibility ◯ I (we) have no other coverage at this time ◯ Other: _____

Section 6: Health Information

Please answer the following health questions regarding any medical conditions or medical treatment for you and your family.

1. Have you or any of your dependent(s) been diagnosed or treated for any of the following conditions in the past five (5) years?

A. Cardiac Disorder	◉ Yes ○ No	I. Immune System Disorder	○ Yes ○ No
B. Cancer / Tumor (any form)	○ Yes ◉ No	J. Alcohol / Drug Abuse	○ Yes ○ No
C. Diabetes	○ Yes ○ No	K. Mental / Nervous Disorder	○ Yes ○ No
D. Kidney Disorder	○ Yes ○ No	L. Neuromuscular Disorder	○ Yes ○ No
E. Respiratory Disorder	○ Yes ○ No	M. Stomach / Gastrointestinal	○ Yes ○ No
F. Liver Disorder	○ Yes ○ No	N. Arthritis, Back, Bone, Joint Disorder	○ Yes ○ No
G. High Blood Pressure	○ Yes ○ No	O. Seizures, Convulsions, Epilepsy	○ Yes ○ No
H. Reproductive Disorders	○ Yes ○ No	P. Any Other Medical Condition (not listed above)	○ Yes ○ No

2. Have you or any of your dependent(s) had any medical conditions in the past 24 months requiring medical care, surgery or hospitalization that exceeded $5000 in medical expenses? ○ Yes ○ No

   If Yes, please provide information on who and for what conditions in space provided below.

3. Are you or any of your dependent(s) anticipating hospitalization or surgery, or had surgery or hospitalization recommended that has not been performed? ○ Yes ○ No

   If Yes, please provide information below

4. Are you or any dependent(s) currently pregnant or suspect you / they may be pregnant? ○ Yes ○ No

   If Yes, please provide due date and detail in space provided below

5. Are you or any dependent(s) disabled ○ YES ○ NO If YES, please indicate name(s):

If you answer "Yes" to any of the questions above, please provide detail in space provided below.
(If needed, please attach additional sheets, signed and dated by the employee subscriber.)

Question Number	Family Member	Disease / Diagnosis / Treatment	Date of Onset Month / Year	Date Last Seen By Physician	Remaining Symptoms or Problems

6. Prescriptions / Medications - List any medications, prescriptions, or injections taken in the last 12 months.
(Attach Additional Sheets as Necessary.)

Family Member	Medication / Rx / Injection	Dosage	Medical Condition

Agreements

The answers and statements on this Employee Health Application are true and complete. I agree that they shall form a part of the contract of insurance under which I am applying for coverage. I understand and agree that the insurance applied for shall not take effect until approved by the insurance carrier at its Home Office. I have read, or have had read to me, the completed application and I realize that any false statements or misrepresentation in the application may result in loss of coverage under the contract.

Medical Authorization

I authorize any of the following to disclose any data it has on me, my health or on the health of my family. (1) any physician or other medical practitioner; (2) any hospital, clinic or other medical or medically related facility; (3) any insurance company; (4) The Medical Information Bureau; (5) any other organization, institution, or person that has any data on me or my health or on the health of my family. A copy of this shall be as valid as the original.

Fraud Warning

Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Section 7: Employee Signature

I hereby authorize my healthcare providers to disclose information from my medical records to respective carriers the extent necessary to for underwriting and benefit eligibility. In the event that I enroll, I hereby agree to abide by the terms and conditions of all benefit plan summary documents, which contain the benefits, limitations, and exclusions applicable to my health and other benefit coverage. Upon request, a customer service representative can explain my benefit coverage options. I have read and understand the above conditions and declarations.

Employee Signature: _____ **Date:** _____