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CONNECTICUT
INDIVIDUAL MARKETS HEALTH STATEMENT

APPLICANT AND FAMILY INFORMATION

PLEASE USE BLACK OR BLUE INK ONLY

PART A
COMPLETE FOR YOU AND ANY FAMILY MEMBERS APPLYING FOR COVERAGE:

	FIRST NAME	INITIAL	LAST NAME	HEIGHT	WEIGHT	DATE OF BIRTH	SEX M/F	SOCIAL SECURITY #
APPLICANT				/		/ /		
SPOUSE				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		
DEPENDENT				/		/ /		

PART B — YES NO

1. IS ANY PERSON TO BE INSURED CURRENTLY ON MEDICARE? ☐ ☐
2. HAS ANYONE HAD HEALTH OR LIFE INSURANCE MODIFIED, POSTPONED OR RATED? PLEASE SUBMIT DETAILS ______ ☐ ☐

PART C

1. Are you or your spouse or any dependent to be insured currently disabled or unable to perform their normal activities? ☐ ☐
2. Have you or any dependent to be insured been hospitalized, had surgery or been advised to have surgery within the past 5 years for any reason? ☐ ☐
3. Are you or any dependents to be insured currently pregnant, or an expectant parent? ☐ ☐
4. Are you or any dependents currently taking any medication? If yes, please specify medication and condition for which it is used: ______ ☐ ☐
5. Do you or any dependents have any conditions or symptoms for which a physician or other medical care provider has not been consulted? ☐ ☐
6. Have you or any dependent had medical expenses in excess of $5,000 in the last 12 months? ☐ ☐

PART D

1. Have you or any dependent to be insured ever had or been told they had, or been medically counseled, consulted or treated for any of the following? (Check **yes** or **no** and **circle the disorder**)
   - A. Chest pain, heart attack, heart murmur, heart trouble, rapid, slow or irregular heart beat, other diseases of the heart, circulatory system or blood vessels, varicose veins, phlebitis, anemia or other disorder of the blood? ☐ ☐
   - B. Cancer, tumor or lymph node enlargement? (Indicate type of cancer and location ______) ☐ ☐
   - C. Sexually transmitted disease? ☐ ☐
   - D. Mental, emotional, nervous disorder, depression, anxiety, psychotherapy or counseling of any kind? ☐ ☐
   - E. Brain disorder, neurologic problems, seizure disorder, any disorder of the central nervous system, stroke or paralysis? ☐ ☐
   - F. Alcohol or drug use, abuse and/or dependency? ☐ ☐
   - G. Medical diagnosis of AIDS (Acquired Immuno Deficiency Syndrome) or ARC (AIDS Related Complex)? ☐ ☐
   - H. Any disorder of the male/female reproductive organs including infertility and complications of pregnancy? ☐ ☐
   - I. Back, neck, bone, joint problems, Lupus, arthritis or autoimmune disorder? ☐ ☐
   - J. Diabetes? If so, specify date of diagnosis, type of treatment, amount of medications (if any): ______ ☐ ☐
   - K. Any disorder of the stomach, intestines, gallbladder or esophagus? ☐ ☐
   - L. Any disorder of the lungs or respiratory system or Tuberculosis? ☐ ☐
   - M. Any disorder of the kidneys, bladder or urinary tract? ☐ ☐
   - N. Any disorder of the liver or pancreas? ☐ ☐
   - O. Any disorder of the endocrine system or glands? ☐ ☐

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PART E
Within the last two years, have you or any dependent to be insured ever had, been told they had, consulted or treated for any of the following:

	YES	NO		YES	NO		YES	NO
a. Asthma	☐	☐	d. Ear problems	☐	☐	g. Lyme Disease	☐	☐
b. Bronchitis	☐	☐	e. Eye problems	☐	☐	h. Nose/Throat/Sinus problems	☐	☐
c. Chiropractic Care	☐	☐	f. Headaches/Migraines	☐	☐	i. Skin problems/Allergies	☐	☐

PART F

	YES	NO
Have you or any dependent had an examination or treatment for any illness or injury other than those stated above?	☐	☐

GIVE DETAILS ON THE FOLLOWING QUESTIONS BELOW.

Simply listing the name of a primary physician or referring to a physician s name will not be considered a substitute for listing fully detailed answers to the questions on this and the previous page.

If you checked (✔) yes to any question, please provide a complete explanation in Part G below.

PART G
DETAILS TO HEALTH HISTORY

If more space is needed, attach separate page which must be signed and dated.

Question Number	Person Affected	Condition/ Diagnosis	Treatment (Surgeries/Medications)	Treatment Dates from/to	Date of Full Recovery	Name, Address, Phone Number of Physician, Hospital/Institution

I hereby represent and agree that all the answers and statements in this request are full, complete and true, to the best of my knowledge and belief, and understand these said answers and statements form the basis upon which insurance will be made effective. I understand that omissions, misrepresentations or misstatements about medical history could result in the denial of an otherwise valid claim and rescission, voiding or reformation of insurance.

Date____________ Applicant Signature ____
(If applicant is under 18, parent or guardian signature is required.)

Anthem

Anthem Blue Cross and Blue Shield
Statement of Domestic Partnership

Note: Keep a copy of this document for your records and send the original attached with your Enrollment/Change Application.

<u>Policy Holder/Subscriber</u>

Policy # ______________________
(for existing members only)

Name ____________________________

Home Address ____________________________

____

Social Security #______________________

Birth Date: ______________________

<u>Domestic Partner</u>

Name ____________________________

Home Address ____________________________

____

Social Security # ______________________

Birth Date: ______________________

We the undersigned attest to the following:

1) Each party is the sole Domestic Partner of the other.

2) Each party is at least eighteen (18) years of age.

3) Both parties currently share a common legal residence and have shared said residence for at least 12 months prior to application for Domestic Partner coverage.

4) Neither party is married to another person.

5) Both parties are in a relationship of mutual support, caring, and commitment and intend to remain in such a relationship in the indefinite future.

6) Neither party is related to the other by adoption or blood to a degree of closeness that would bar marriage in the state in which they reside, except for those states that legally recognize Domestic Partners as a legal valid marriage.

7) Domestic Partners are responsible for basic living expenses.

8) Domestic Partners must have in effect and provide proof of any one of the following:
   a) Designation of the Partner as beneficiary for life insurance and retirement contract; or
   b) Designation of the Partner as primary beneficiary in the Policy Holder/Subscriber s will; or
   c) Documentation by one Partner designating the other Partner as his/her agent for:
      - Personal relationship issues, or
      - Health Care decisions, or
      - Health Care agent

9) Neither party has filed a Termination of Domestic Partnership within the preceding 12 months.

Signatures and Notary Public Seal required on back.