MACo Health Care Trust
Group Health Statement

To keep this statement confidential, please submit it in a sealed envelope.

County or District Name: ____

Please print **-** Include information for yourself and dependent(s) that intend to be covered.

	Name	Relationship	Date of Birth	Height	Weight
Employee					
Dependent					
Dependent					
Dependent					
Dependent					

Please answer YES or NO to each of the following questions for yourself and each of your dependents listed above.
(If you answer YES to any of the questions below, please explain referencing the question number in the section following question number 20).

		Yes	No
1	Been admitted to a hospital or had surgery in the past five (5) years? (If yes, explain below)		
2	Within the past two years, have you or any dependent listed above, been disabled and/or incurred medical costs exceeding $5,000.00? (If yes, explain below)		
3	Been told that it may be necessary to be admitted to the hospital or have surgery in the future? (if yes, explain below)		
Been diagnosed with, treated for or had treatment for any of the following: (If yes, explain below)			
4	Heart or artery disease including heart attack, stroke, aneurysm, arteriosclerosis, chest pain, rheumatic fever or heart murmur?		
5	Hypertension?		
6	Cancer, tumor or other malignancy?		
7	Diseases of the kidney, liver, gall bladder, pancreas or male/female organs including venereal disease?		
8	Arthritis, back pain, rheumatic fever or musculoskeletal/joint problems?		
9	AIDS, AIDS-related complex or other immune deficiency disorders (except HIV infection), infections or chronic infection problems?		
10	Alcohol or substance abuse, mental/nervous disorders?		
11	Ulcer, colitis, difficulty swallowing, stomach problems, hernia or rectal problems?		
12	Diabetes, cystic fibrosis albumin or sugar in the urine or other endocrine problems?		
13	Asthma, emphysema, tuberculosis, pleurisy or other neuromuscular disorder?		
14	Paralysis, epilepsy, multiple sclerosis or other neuromuscular disorder?		
15	Bleeding or blood disorders, (except for HIV infection)?		
Other Conditions/Information			
16	Are you or any dependent listed above now pregnant?		

GROUP HEALTH STATEMENT *(continued)*

Please print - Include information for yourself and dependent(s) that intend to be covered.

Employee Name	Date of Birth

		Yes	No
17	Any other medical condition that has not been disclosed above? If so, describe in detail below?		
18	Have you or any of your dependents listed above smoked in the last two years? If yes, date stopped: / /		
19	Are you or any of your dependents listed above taking any medication (except contraceptives) that require a prescription by a physician?		
20	Have you or your dependents listed above gained or lost more than 20 pounds in the last year? Gained __________ Lost _____________		

Complete the following for any "yes" responses from questions 1 to 20: (Please indicate the question number below)

Q #	Dependent (or Self) Name	Name & Address of Physician or Clinic	Date Treatment Began & Ended	Name of Condition(s) Illness(es) Treated	Indicate Treatment Rendered & Current Status (Recovered, Still in Treatment?) Include Name of Medication (if taken) and Dates Prescribed

Attach additional sheets if necessary

By signing below, I certify that my answers and statements are true and complete to the best of my knowledge and belief. I understand that this Group Health Statement is a part of my and my dependents' application to be covered by my employer's group health plan through the MACoHCT.

I understand that if I have misrepresented or omitted any material fact that my and my dependents' coverage may be cancelled and my employer's contract rescinded.

EMPLOYEE'S SIGNATURE: ____ DATE SIGNED: ___________________________

End of Form