ADVANTAGE

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HEALTH STATEMENT

Please complete the following health questionnaire. Your answers to the questions below will not affect your eligibility for coverage, and will not be used as a basis to exclude coverage for any medical condition, with the exception of a pre-existing condition if applicable to the terms of your group health plan. Regarding your dependents, only provide information about the dependents you listed for coverage. In answering this questionnaire, you should not include any genetic information. Please do not include any family medical history or any information related to genetic testing, genetic services genetic counseling or genetic diseases for which you believe you may be at risk.

APPLICANT DATA

Last	First	MI	SSN	Date of Birth	Sex	Height	Weight

Street Address	City, State, Zip	Phone # Day ( ) Evening ( )

Dependent Address (if different from employee)

Employer	Occupation	Marital Status o Single o Married o Divorced

Type of Coverage Requested

o Employee Only o Employee + Spouse o Employee + Child(ren) o Family o No Coverage (complete the following for each dependent)

Last	First	MI	Date of Birth	Sex		Height	Weight	Tobacco user?	Disabled?
				M	F			YES NO	YES NO
				M	F			YES NO	YES NO
				M	F			YES NO	YES NO
				M	F			YES NO	YES NO
				M	F			YES NO	YES NO

HEALTH DATA

A. Have you or the dependents for which you seek coverage been diagnosed by a physician as having, treated for or had treatment for any of the following:

CONDITIONS	YES	NO	CONDITIONS	YES	NO	CONDITIONS	YES	NO
1. AIDS/ARC			19. Other Lung Disorders			33. Heart Attack / MI		
2. Arthritis			20. Liver Disorders			34. Coronary Artery Disease/Bypass Surgery		
3. Rheumatoid Arthritis			21. Congenital Disease/Defect			35. Angioplasty		
4. Osteo Arthritis			22. Paralysis			36. Congestive Heart Failure		
5. Back/Spinal Disorders			23. Multiple Sclerosis/Other Neurological Disorders			37. Pacemaker		
6. Back Strain/Sprain			24. Cerebral Palsy			38. Ischemic Heart Disease		
7. Scoliosis			25. Epilepsy			39. Alcohol Or Drug Dependency		
8. Spina Bifida			26. Parkinson's			40. Attempted Suicide		
9. Ulcerative Colitis			27. Alzheimer's Disease			41. Anorexia/ Bulimia		
10. Diverticulitis			28. Hemophilia			42. Chronic Depression		
11. Crohn's Disease			29. Kidney/Urinary Disorders			43. Other Mental/Emotional Disorders		
12. Gastric/Peptic Ulcer			30. Tumors/Growths			44. Venereal Disease		
13. Other Bowel/Stomach Disorders			31. Deafness			45. High Blood Pressure		
14. Stroke (Date)			32. Diabetes (Juvenile/Mellitus)			If yes, give last 3 pressures and dates		
15. Cancer, Leukemia Or Melanoma			If yes, give last 3 blood sugars & dates			A. B. C.		
16. Emphysema			A.			46. Currently Pregnant		
17. Chronic Bronchitis			B.			If yes, what is expected due date?		
18. Asthma			C.			If yes, is pregnancy high risk or are complications expected? Explain. In answering this question, do not include any genetic information. Please do not include any family medical history or any information related to genetic testing, services, counseling or diseases for which you believe you may be at risk.		

B. If you or any of your listed dependents answered "yes" please explain below (use additional paper, if necessary). Please indicate specific location of condition. Example: Right knee, details of injury, ailment or condition.

Patient's Name	Condition #	Diagnosis and Type of Treatment	Hospitalized?	Attending Physician	Date(s) of Treatment(s)

C. Have you or any of your dependents consulted a physician during the past five years for any condition not listed in Section B? (Do not include physicals with normal results.) o Yes o No If yes, explain. In answering this question, you should not include any genetic information. Please do not include any family medical history or any information related to genetic testing, genetic services genetic counseling or genetic diseases for which you believe you may be at risk.

Patient's Name	Condition	Treatment/Medication	Date Treated or Consulted	Degree of Recovery
			from to	
			from to	
			from to	
			from to	

D. Do you or any of your dependents currently take prescribed medications (including fertility drugs)? o Yes o No If yes, explain.

Name of Person	Medication/Amount per Day	Condition

E.	Have you or any your dependents ever had abnormal results on any of the following: blood count, blood test, Wasserman, urinalysis, EKG, X-ray or ultrasound. o Yes o No
F.	Have you or any of your dependents listed been treated on an outpatient basis; testing, rehabilitation, home health care or emergency room within the last two years. o Yes o No If yes, explain. In answering this question, you should not include any genetic information. Please do not include any family medical history or any information related to genetic testing, genetic services genetic counseling or genetic diseases for which you believe you may be at risk.
G.	Has any insurance company refused or restricted any health coverage on any person listed on this health statement within the last five years? o Yes o No If yes, explain.
H.	List anyone on this health statement under the age of 65 who is covered by Medicare.
I.	Do you or any of your dependents listed have a condition covered by Worker's Compensation? o Yes o No If yes, explain.

Authorization to Obtain and Disclose Information

I authorize any physician, medical practitioner, hospital, medical clinic, or other healthcare provider to disclose to ADVANTAGE or its authorized medical, underwriting and claims representatives all information and records relating to health status, physical or mental medical conditions, claims history, use of health care services, medical history, genetic information, evidence of insurability (includes conditions arising out of acts of domestic violence, and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), disability or any other information relating to me or my listed dependents. Such records and information may be used by ADVANTAGE now or in the future only in connection with the underwriting of my application for insurance, the reinstatement of any policy issued and any claims on any policy issued. I understand ADVANTAGE can condition enrollment upon the completion of this form. I also understand that any information obtained will not be disclosed by ADVANTAGE to any person or organization except its reinsurers, other persons or other organizations performing business or legal services in connection with my application or policy, or as may be required by law or as I further authorize. A photocopy of this authorization will be as valid as the original; however, I understand in the event a policy is not issued, this authorization to obtain and disclose information will be null and void. 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 Employee Application, including this Health Statement, is a part of my and my listed dependents' application to be added to my employer's ADVANTAGE Health Solutions plan contract or policy. I understand that if I have misrepresented or omitted any material fact that my coverage may be cancelled or my employer's contract rescinded. I have read the foregoing questions and declare the answers to be true and complete to the best of my knowledge and belief. I realize that any material misstatement or omission in this Health Statement may result in denial and/or recession of the coverage.

Applicant's Signature **Date**

Spouse's Signature (if Spouse is to be covered) **Date**

WARNING: Any person who, with the intent to defraud or knowingly facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive material statement is guilty of insurance fraud.

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