GROUP INFORMATION	TO BE COMPLETED BY GROUP ADMINISTRATOR Group Number _____ Effective Date _____ Subgroup _____ Class _____

IDAHO UNIVERSAL HEALTH STATEMENT ADDENDUM

Please type or print legibly in black ink and complete all applicable sections.

This addendum **does not** need to be **completed in all cases.**

Completion NOT required	Completion IS required	Completion requirement differs by carrier
Small employer plan with 50 or fewer eligible employees seeking ACA-compliant coverage	Employer plans with 51-100 eligible employees seeking fully insured coverage	- Employer plans participating in specialized funding or trust arrangements - Employer plans with healthcare reform “grandfathered” or “grandmothered” status

Please refer to your agent or sales representative for any additional clarification regarding the applicability of this addendum.

SECTION 1 EMPLOYER INFORMATION

1. Name of Employer

SECTION 2 APPLICANT/DEPENDENT INFORMATION

Applicant/Dependent’s Name (first, initial, last)	Relationship (spouse, child, stepchild, etc.)	Date of Birth (mm/dd/yyyy)	Height	Weight
Applicant				
Dependent 1				
Dependent 2				
Dependent 3				
Dependent 4				
Dependent 5				
Dependent 6				

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SECTION 3 HEALTH STATEMENT

PLEASE ANSWER BELOW	Have you or any family member listed on this application ever seen a doctor, been diagnosed with, had treatment, hospitalization, medications, tests or been advised to have treatment or surgery for any of the following? If yes, please provide details on grid below. NOTE: The list of specific conditions is not comprehensive.
a. Cancer/Tumor ☐Yes ☐No	Brain Breast Cervical Colon Leukemia Liver Lung Lymphoma Melanoma Non-Malignant Tumor Ovarian Prostate Testicular Other Cancer
b. Heart/Circulatory ☐Yes ☐No	Aneurysm Angina Angioplasty/Stent Blood Clots/Disorders Bypass Cholesterol/ Triglycerides Congestive Heart Failure Hemophilia High Blood Pressure Pacemaker/ICD Stroke
c. Reproductive ☐Yes ☐No	Breast Disorders Endometriosis Fibroids Infertility Menstrual Disorders
d. Intestinal/Endocrine/Liver ☐Yes ☐No	Chronic Pancreatitis Cirrhosis Colon Disorder Crohn's Diabetes (I/II) Gall Bladder Gastric Bypass Hepatitis B/C Liver Disorder Pituitary Disorder Reflux Ulcer Ulcerative Colitis
e. Brain/Nervous ☐Yes ☐No	ALS Alzheimer's Cerebral Palsy Cyst Head Injury Migraines Multiple Sclerosis Paralysis Parkinson's Disease Seizures/Epilepsy
f. Immune ☐Yes ☐No	AIDS Arthritis (Rheumatoid/Psoriatic) HIV+ Immunodeficiency Lupus Psoriasis Scleroderma
g. Lung/Respiratory ☐Yes ☐No	Allergies Asthma Chronic Bronchitis COPD Cystic Fibrosis Emphysema Lung Disorders Pneumonia Sarcoidosis Sleep Apnea Tuberculosis
h. Eyes/Ears/Nose/Throat ☐Yes ☐No	Acoustic Neuroma Cataracts Chronic Ear Infections Chronic Sinusitis Cleft Lip/Palate Deviated Septum Glaucoma Retinopathy
i. Urinary/Kidney ☐Yes ☐No	Bladder Disorders Kidney Disorders Kidney Stones Polycystic Kidney Disease Prostate Disorder Renal Failure
j. Bones/Muscles ☐Yes ☐No	Back Disorder Bulging/ Herniated Disc Chronic Pain Syndrome Fibromyalgia/Chronic Fatigue Syndrome Joint Injury Knee Disorder Neck Disorder Osteoarthritis Shoulder Disorder Spina Bifida
k. Behavioral Health ☐Yes ☐No	ADHD Alcohol/Drug Anxiety/Depression Autism Bipolar Depression Eating Disorder Inpatient Mental Health Manic Depression Substance Abuse Suicide Attempt
l. Transplant ☐Yes ☐No	Bone Marrow Discussed Possible Future Transplant Organ Stem Cell Transplant Complications
m. Pregnant ☐Yes ☐No	Are you or any family member listed on this application currently pregnant? If so, then on the grid below include due date, details about any complications, surrogacy information (if applicable), etc…
n. Hospital/Surgery ☐Yes ☐No	Have you or any family member listed on this application been hospitalized, or had surgery, during the last 5 years?
o. Future Treatment/Surgery ☐Yes ☐No	Have you or any family member listed on this application ever been advised to have any treatment and/or surgical operation(s) that you or any family member have not yet had?
p. Congenital Conditions ☐Yes ☐No	Do you or any family member listed on this application have any congenital conditions that have not previously been disclosed on the detail grid below for a previous question?
q. $5,000+ Claims ☐Yes ☐No	Have you or any family member listed on this application had claims in excess of $5,000 that have not previously been disclosed on the detail grid below for a previous question?
r. Other ☐Yes ☐No	Do you or any family member listed on this application suffer from any chronic or recurring ailments, illnesses or other departures from good health, regardless of whether a physician or other health care professional has been consulted that has not previously been disclosed on the detail grid below for a previous question?
s. Prescriptions ☐Yes ☐No	During the past 12 months, have you or any family member listed on this application received a prescription for medication from a physician or taken any prescribed medication not previously been disclosed on the detail grid below for a previous question?
t. Denied/Refused Coverage ☐Yes ☐No	Have you or any family member listed on this application ever been refused or issued restricted health insurance coverage?

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SECTION 3 HEALTH STATEMENT CONTINUED

Item (a – t) *from previous page*	Person Affected	Date Condition Began MM/YYYY	Name of Disease, Symptom or Condition – Include Type of Treatment	Name of Hospital and Number of Days	Date Last Treated	Was Recovery Complete?	Drugs – Include Type or Name, Dosage, Strength and Duration	Name of Physician

SECTION 4 AFFIRMATION

I affirm the answers in this "Idaho Universal Health Statement Addendum" are complete and correct. I am providing these answers as an addendum to my completed Idaho Universal Group Application, Form No. ID Grp App and understand this will become a part of that application. Any and all provisions delineated in the Idaho Universal Group Application apply to this addendum.

Signature of Employee _____ Signature Date (mm/dd/yyyy)_____

Signature of Spouse _____ Signature Date (mm/dd/yyyy)_____
(if applying for coverage)

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