

Please complete all items. Include information on you (the subscriber) and all other family members you wish to cover under this plan. **Please use blue or black ink.** Any errors made should be crossed out and initialed. Please do not use correction fluid such as Liquid Paper. **INCOMPLETE APPLICATIONS WILL BE RETURNED.**

### SECTION I

List the name, height and weight of each family member applying for coverage in this plan.

Applicant: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Spouse: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Dependent: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Dependent: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Dependent: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Dependent: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**Phone Numbers:** Daytime: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Have you or any member of your family previously applied for an individual HMSA plan? **YES**  **NO**

If yes, please note: **Family member / Plan name / Date of application**

### SECTION II

1. Has any applicant who is to be covered under this membership been consulted in regards to, received advice, been recommended for treatment, sought treatment, received treatment, or been hospitalized for any of the following conditions within the past five years:

	YES	NO
<b>A. Brain/Nervous System:</b> Dizziness, weakness, paralysis, transient ischemic attack (TIA), stroke, loss of consciousness, any seizure disorder, or Alzheimer's disease?	<input type="checkbox"/>	<input type="checkbox"/>
<b>B. Heart/Circulatory System:</b> A heart condition of any kind, including chest pain, heart murmur, palpitations, valve problems, heart disease, heart attack, elevated cholesterol level, coronary artery disease, aneurysm, pacemaker, high blood pressure, blood clot and/or blood disorder, or bleeding problems?	<input type="checkbox"/>	<input type="checkbox"/>
<b>C. Lungs/Respiratory System:</b> Spitting and/or coughing up blood, emphysema, tuberculosis, chest and/or lung problems, chronic obstruction of the airway, pulmonary embolism, or tightness/difficulty breathing?	<input type="checkbox"/>	<input type="checkbox"/>
<b>D. Digestive System:</b> Intestinal problems, rectal and/or bowel problems, liver or gallbladder disease, pancreatitis, colitis, cirrhosis, ulcers, polyps, esophagus problems, or Crohn's disease?	<input type="checkbox"/>	<input type="checkbox"/>
<b>E. Birth Defects:</b> Or congenital abnormalities (i.e., club foot, cleft lip/palate, spina bifida)?	<input type="checkbox"/>	<input type="checkbox"/>
<b>F. Urinary Tract:</b> Urinary, bladder and/or kidney problems; chronic renal; or end-stage renal disease?	<input type="checkbox"/>	<input type="checkbox"/>
<b>G. Metabolic System:</b> Diabetes, lupus, adrenal and/or thyroid disorder, Reynard's disease, AIDS/ARC, HIV-positive, or Karposi sarcoma?	<input type="checkbox"/>	<input type="checkbox"/>
<b>H. Muscular/Skeletal System:</b> Arthritis; fibromyalgia; bursitis; hernia; disorder/injury or pain of the back, spine, bone, joint, muscle or tendon; carpal tunnel syndrome; or chronic pain?	<input type="checkbox"/>	<input type="checkbox"/>
<b>I. Cancer or Tumor:</b> Including leukemia, tumor, melanoma, cyst or abnormal growth(s), or enlarged lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>
<b>J. Skin Disorders:</b> Including eczema or psoriasis?	<input type="checkbox"/>	<input type="checkbox"/>

**K. Breast (male or female):** Fibrocystic disease, lumps, nodules, discharge or abnormal mammogram? YES  NO

**L. Reproductive System (as applicable):**

**1. Male:** Prostate problems, infections, impotency, infertility or venereal diseases?  YES  NO

**2. Female:** Infertility, menstrual disorders, cysts, infections, venereal disease, abnormal bleeding, abnormal Pap results, or endometriosis?  YES  NO

**a) Does any applicant menstruate?**  YES  NO  
 If yes, date of last pelvic exam: \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Date: \_\_\_\_\_

**b) Is any applicant pregnant?**  YES  NO  
 Name: \_\_\_\_\_ Due Date: \_\_\_\_\_  
 Name: \_\_\_\_\_ Due Date: \_\_\_\_\_

**2.** Has any applicant undergone diagnostic testing, treatment or surgery of any kind (including oral surgery)?  YES  NO

**3.** Has any applicant undergone cosmetic or reconstructive surgery?  YES  NO

**4.** Has any applicant been treated for any mental, nervous, emotional, behavioral or eating disorder; depression; attempted suicide; bi-polar disorder, or schizophrenia?  YES  NO

**5.** Is any applicant a member of a support or therapy group for any mental health condition?  YES  NO

**6.** Has any applicant been prescribed medication in the past 12 months or is currently taking prescribed medication?  YES  NO

If "yes" please complete "MEDICATIONS" in Section IV of this statement for each person to which this question applies.

**SECTION II (continued)**

**7.** Has any applicant used illegal or controlled substances or drugs at any time in the past five years? YES NO

If yes, please indicate:

Family member: \_\_\_\_\_  
 Drug name: \_\_\_\_\_ # of years: \_\_\_\_\_  
 Family member: \_\_\_\_\_  
 Drug name: \_\_\_\_\_ # of years: \_\_\_\_\_

**8.** Has any applicant engaged in substance or alcohol abuse or undergone alcohol/substance abuse rehabilitation or detoxification treatment? YES NO

If yes, please indicate:

Program/Facility: \_\_\_\_\_  
 Family member: \_\_\_\_\_ Dates: \_\_\_\_\_  
 Program/Facility: \_\_\_\_\_  
 Family member: \_\_\_\_\_ Dates: \_\_\_\_\_

**9.** Has any applicant ever been eligible for or received benefits from Medicare, workers' compensation, no-fault insurance, or any other medical disability program? YES NO

**10.** Within the past five years, has any applicant smoked cigarettes or cigars or used chewing tobacco? YES NO

If yes, please indicate:

Name: \_\_\_\_\_ # of years: \_\_\_\_\_  
 Name: \_\_\_\_\_ # of years: \_\_\_\_\_  
 Name: \_\_\_\_\_ # of years: \_\_\_\_\_  
 Name: \_\_\_\_\_ # of years: \_\_\_\_\_

**SECTION III**

Please provide detailed explanations for each "yes" answer above by completing the following for all family members applying (use additional paper if necessary):

**1.** Question # \_\_\_\_\_  
 Family member: \_\_\_\_\_  
 Condition or illness: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician name & address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2.** Question # \_\_\_\_\_  
 Family member: \_\_\_\_\_  
 Condition or illness: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician name & address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**3.** Question # \_\_\_\_\_  
 Family member: \_\_\_\_\_  
 Condition or illness: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician name & address \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SECTION IV**

List all medications taken (or taking) within the past 12 months for all family members applying (use additional paper if necessary):

**1.** Family member: \_\_\_\_\_  
 Medication name: \_\_\_\_\_  
 Prescribing physician: \_\_\_\_\_  
 Condition for which medication was prescribed: \_\_\_\_\_  
 \_\_\_\_\_  
 Date medication was started: \_\_\_\_\_  
 Date medication was finished: \_\_\_\_\_

**2.** Family member: \_\_\_\_\_  
 Medication name: \_\_\_\_\_  
 Prescribing physician: \_\_\_\_\_  
 Condition for which medication was prescribed: \_\_\_\_\_  
 \_\_\_\_\_  
 Date medication was started: \_\_\_\_\_  
 Date medication was finished: \_\_\_\_\_

**3.** Family member: \_\_\_\_\_  
 Medication name: \_\_\_\_\_  
 Prescribing physician: \_\_\_\_\_  
 Condition for which medication was prescribed: \_\_\_\_\_  
 \_\_\_\_\_  
 Date medication was started: \_\_\_\_\_  
 Date medication was finished: \_\_\_\_\_

**THIS APPLICATION MUST BE SIGNED BY ALL APPLICANTS AGE 18 AND OLDER. IF THE APPLICANT IS UNDER 18, A PARENT OR LEGAL GUARDIAN'S SIGNATURE IS REQUIRED.**

Signature \_\_\_\_\_ Date \_\_\_\_\_  
APPLICANT (18 AND OVER)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
APPLICANT (18 AND OVER)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
PARENT/LEGAL GUARDIAN

Signature \_\_\_\_\_ Date \_\_\_\_\_  
PARENT/LEGAL GUARDIAN

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