



**PERSONAL HEALTH STATEMENT
OF DEPENDENT**

Section I - To be Completed by Policyholder

POLICY / PLAN NO. 107103 BILLING GROUP NO. _____ BILLING SUBGROUP / UNIT NO. _____ CLASS _____
 POLICYHOLDER (EMPLOYER) Semper Fit and Exchange Services Division CERT. NO. _____ DATE EMPLOYED _____
 NAME OF EMPLOYEE _____ DATE OF BIRTH _____ SEX M F
 EMPLOYEE'S HOME ADDRESS _____ LATE APPLICANT: YES NO

Section II - To be Completed by Employee (The following statements by the employee relate to the dependent)

NAME OF DEPENDENT _____ RELATIONSHIP _____
 DEPENDENT'S DATE OF BIRTH _____ SEX M F DEPENDENT'S SOCIAL SECURITY NO. _____

	ANSWER YES OR NO	IF ANY PART IS ANSWERED "YES" GIVE PARTICULARS AND DATES
1. DOES THE DEPENDENT HAVE ANY DISEASE OR AILMENT AT THE PRESENT TIME?	
2. IF THE ANSWER TO QUESTION NO. 1 IS YES, DOES THE DEPENDENT CONTEMPLATE OR HAS A PHYSICIAN RECOMMENDED AN OPERATION OR ANY MEDICAL TREATMENT FOR THIS CONDITION?	
3. DURING THE PAST FIVE YEARS HAS THE DEPENDENT	
A. HAD ANY DISEASE OF THE KIDNEYS?	
B. BEEN ADVISED THAT HE OR SHE HAS DIABETES? (IF YES, PROVIDE TWO READINGS AND MEDICATIONS).	
C. HAD ANY DISEASE OF THE HEART?	
D. BEEN ADVISED THAT HE OR SHE HAS ABNORMAL BLOOD PRESSURE? (IF YES, PROVIDE TWO READINGS AND MEDICATIONS).	
E. HAD ANY DISEASE OF THE STOMACH OR BOWEL?	
F. BEEN DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION FOR ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR ANY AIDS RELATED CONDITION (ARC)?	
G. HAD ANY DISEASE OF THE LUNGS?	
H. HAD ANY DISEASE OF THE NEUROLOGICAL SYSTEM?	
I. HAD ANY DISEASE OF THE GENITAL OR URINARY TRACT?	
J. HAD ANY DISEASE OF THE MUSCULO-SKELETAL SYSTEM?	
K. HAD ADVICE, ATTENDANCE OR TREATMENT BY A PHYSICIAN, PRACTITIONER OR ANOTHER PERSON? (GIVE DATES AND REASON)	
L. HAD TREATMENT OR OBSERVATION IN A CLINIC, HOSPITAL OR RESIDENTIAL TREATMENT PROGRAM? (GIVE DATES AND REASON)	
4. A. HAS THE DEPENDENT EVER APPLIED FOR LIFE, HEALTH, OR ACCIDENT COVERAGE AND BEEN DECLINED, POSTPONED OR RESTRICTED, OR HAS A POLICY BEEN ISSUED AND AFTERWARDS CANCELLED?	
B. HAS THE DEPENDENT EVER RECEIVED INSURANCE BENEFITS OR COMPENSATION OF ANY KIND FOR ILLNESS OR INJURY?	

5. WHEN AND FOR WHAT DID THE DEPENDENT LAST CONSULT A PHYSICIAN? GIVE DATE, NAME AND ADDRESS OF PHYSICIAN OR PRACTITIONER, AND NATURE OF INJURY OR ILLNESS.
 6. WHAT IS DEPENDENT'S HEIGHT? _____ FEET _____ INCHES, WEIGHT _____ POUNDS? 7. IS DEPENDENT PREGNANT? YES NO
 8. APPROVAL REQUESTED FOR FOLLOWING COVERAGES
 DEPENDENT LIFE \$ _____ OTHER (specify) _____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING STATEMENTS AND ANSWERS, EACH OF WHICH I HAVE MADE AND READ, ARE COMPLETE AND TRUE, AND ARE CORRECTLY AND FULLY RECORDED. I UNDERSTAND THAT ANY MISREPRESENTATION CONTAINED HEREIN RELIED ON BY THE COMPANY MAY BE USED TO REDUCE OR DENY A CLAIM OR VOID THE CONTRACT WITHIN THE CONTESTABLE PERIOD IF SUCH MISREPRESENTATION MATERIALLY AFFECTS THE ACCEPTANCE OF THE RISK. I HEREBY DECLARE THAT A DUPLICATE COPY OF THIS INSTRUMENT CONTAINING THE ABOVE STATEMENTS OR ANSWERS TOGETHER WITH ANY EXPLANATIONS THERE TO HAS BEEN FURNISHED TO ME BY THE INSURANCE COMPANY.

WITNESS _____ SIGNATURE OF EMPLOYEE _____ DATE _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section III - For UniCare Use

Decision: Approved Day 1 Plan Date of Approval _____ Reviewed by: _____ Regional Service Center _____
 Declined Date Eligible Plan
 If Declined, Reason: _____

DISCLOSURE AUTHORIZATION

PERMISSION TO OBTAIN INFORMATION

I HEREBY AUTHORIZE ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, CLINIC, HOSPITAL OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY, INSURANCE COMPANY, CONSUMER REPORTING AGENCY, OR EMPLOYER, OR ANY OTHER SIMILAR PERSON, INSTITUTION, OR ORGANIZATION TO GIVE THE UNICARE LIFE & HEALTH INSURANCE COMPANY ("THE COMPANY") ANY AND ALL INFORMATION AND COPIES OF RECORDS RELATING TO THE APPLICANT NAMED ON THIS FORM AND ANY PROPOSED COVERED DEPENDENTS.

TYPES OF INFORMATION REQUIRED

THE INFORMATION REQUESTED MAY INCLUDE ALL INFORMATION AVAILABLE AS TO DIAGNOSIS AND TREATMENT WITH RESPECT TO ANY PHYSICAL OR MENTAL CONDITION.

USE AND DISCLOSURE

THE INFORMATION COLLECTED UNDER THIS AUTHORIZATION WILL BE USED FOR DETERMINING YOUR ELIGIBILITY AND YOUR PROPOSED COVERED DEPENDENTS ELIGIBILITY, ALL OR PART OF THE INFORMATION MAY BE USED TO DETERMINE ELIGIBILITY FOR BENEFITS UNDER ANY POLICY OR BENEFIT PROGRAM ADMINISTERED BY THE COMPANY AND FOR OTHER BUSINESS PURPOSES IN CONNECTION WITH THE INSURANCE RELATIONSHIP. IT MAY ALSO BE SENT TO ANY REINSURANCE COMPANY WITH WHICH THE COMPANY DOES BUSINESS AND ANY OTHER ORGANIZATION WHICH PERFORMS SERVICES IN CONNECTION WITH THE INSURANCE RELATIONSHIP. IN ADDITION, YOUR EMPLOYER MAY HAVE ACCESS TO YOUR ANSWERS TO THE QUESTIONS ON THE ATTACHED PERSONAL HEALTH STATEMENT. IT IS UNDERSTOOD THAT THE COMPANY WILL OBTAIN PERMISSION FROM THE UNDERSIGNED BEFORE ANY OF THE INFORMATION COLLECTED IS DISCLOSED TO ANY PERSON OR ORGANIZATION OTHER THAN AS SPECIFIED IN OR IMPLIED BY THIS AUTHORIZATION.

COPY OF AUTHORIZATION

I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION. I AGREE THAT A PHOTOCOPY OF THIS AUTHORIZATION MAY BE USED TO OBTAIN INFORMATION.

EFFECTIVE DATE

THIS AUTHORIZATION SHALL REMAIN VALID FOR THIRTY MONTHS AFTER THE DATE OF SIGNING.

NAME OF APPLICANT

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE **OR STATEMENT OF CLAIM** CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME, **AND WITH RESPECT TO NEW YORK STATE RESIDENTS ONLY BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH VIOLATION.**

SIGNATURE _____ DATE _____