State of New Hampshire
Standardized Health Form

☐ New Group ☐ New Employee Add-On ☐ Existing Employee Change

Print clearly and complete this form in black ink.

This Standardized Health Form is required for enrollment. A completed form must be submitted by the deadline determined by your health carrier and must include all requested information for each member to be covered. Missing information will delay processing. Failure to complete this form will affect your coverage. You will not be denied coverage based on your health status nor will your premium rates or benefits be affected by your health status.

SECTION 1 – EMPLOYER/GROUP INFORMATION

Employer/Group Name	Date of Hire	Policy/Group Number	Effective Date

SECTION 2 – EMPLOYEE/DEPENDENT INFORMATION: List yourself and all eligible dependents to be covered.

Last Name	First Name	Sex (M/F)	Relation	Date of Birth (M/D/Y)	Height (ft/ins)	Weight (lbs)	Disabled?
			Employee				☐ Yes ☐ No
			Spouse				☐ Yes ☐ No
			Child				☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

SECTION 3 – EMPLOYEE/COVERAGE INFORMATION Note: A representative from your health carrier may contact you regarding your medical history. **Provide a telephone number and place where you can be contacted during the day.**

Phone: Work: ( ) - Home: ( ) -

Preferred Place to be Contacted During the Day: ☐ Work ☐ Home

Type of Medical Coverage Requested: ☐ Employee Only ☐ Employee – Spouse ☐ Employee – One Child ☐ Employee – Children ☐ Employee – Family (spouse & children)

SECTION 4 – HEALTH INFORMATION: Please provide all requested information for each person to be covered. **If you answer YES to any question, please provide full details in Section 5.**

A. Have you or any person to be covered under this plan been diagnosed with or received treatment in the past 5 years for any of the following conditions:

1. ☐ Yes ☐ No AIDS/HIV
2. ☐ Yes ☐ No Alcohol and/or Drug Abuse or Dependency
3. ☐ Yes ☐ No Aneurysm
4. ☐ Yes ☐ No Arthritis
5. ☐ Yes ☐ No Cancer, Tumor or Neoplasm
6. ☐ Yes ☐ No Congenital Abnormalities
7. ☐ Yes ☐ No Crohn's Disease, Colitis or other Intestinal Disorder
8. ☐ Yes ☐ No Diabetes (include date of onset and current treatment)
9. ☐ Yes ☐ No Disorders of the Heart or Circulatory System
10. ☐ Yes ☐ No Disorder of the Kidneys, Liver or Pancreas
11. ☐ Yes ☐ No Disorder of the Lungs including Asthma, Emphysema or COPD
12. ☐ Yes ☐ No Disorder of the Spine, Discs or Joints
13. ☐ Yes ☐ No Epilepsy or Seizures
14. ☐ Yes ☐ No Hepatitis
15. ☐ Yes ☐ No Hemophilia
16. ☐ Yes ☐ No High Blood Pressure
17. ☐ Yes ☐ No High Cholesterol
18. ☐ Yes ☐ No Lupus/Connective Tissue Disease
19. ☐ Yes ☐ No Mental/Nervous Disorder or Depression
20. ☐ Yes ☐ No Multiple Sclerosis
21. ☐ Yes ☐ No Muscular Dystrophy
22. ☐ Yes ☐ No Neurologic Disorder
23. ☐ Yes ☐ No Organ Transplantation
24. ☐ Yes ☐ No Paralysis (please specify)
25. ☐ Yes ☐ No Stroke or Transient Ischemic Attack (TIA)

SECTION 4 – (Continued)

B. Are you or any person to be covered under this plan currently pregnant, undergoing fertility treatment or an expectant father?
☐ Yes ☐ No If yes, due date: _______________ ☐ Single ☐ Multiple Fetuses? (Please check one)

C. Have you or any person to be covered under this plan been advised to have medical treatment, testing, or surgery at some time in the future? ☐ Yes ☐ No

SECTION 5 – MEDICAL DETAILS: Provide complete details for all YES answers from Section 4. Additional details may be provided on a separate sheet (signed and dated).

Question (e.g. A.1)	Name of Individual	Diagnosis	Treatment and Dates of Treatment	Medication Prescribed	Surgery or Hospitalized?	Recovered?	Treating Physician
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:
				☐ Yes ☐ No Drug:	☐ Yes ☐ No	☐ Yes ☐ No	Name: Phone:

SECTION 6 – STANDARDIZED HEALTH FORM CERTIFICATION: I represent that all statements, answers and information I have given relating to me or my dependents is complete and correct to the best of my knowledge and belief. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance carrier for the purpose of defrauding the company. I also understand that the information I have given will be used by my health carrier and be the basis of reinsurance ceding decisions. I will not be denied coverage based on my health status nor will my premium rates be affected by my health status.

I/we understand that any physician, other healthcare practitioner, hospital or clinic providing treatment to me or any of the eligible dependents covered by this health statement may be contacted for additional healthcare information and I authorize such persons and entities to release medical records and medical information to my health carrier in order to accurately assess medical risk for reinsurance purposes pursuant to NHRSA 420-G:5,1. I understand that if I choose not to provide this release and information, my eligibility for coverage may be denied or enrollment may be delayed. I understand that I have the right to revoke this authorization in writing at any time. If I do revoke this authorization however, I understand the revocation may impact my eligibility or enrollment for coverage. This authorization shall be valid for 60 days from the date of my signing this Standardized Health Form below.

Employee Name (Printed) Employee Signature Date

Spouse Name (Printed)* Spouse Signature Date

* if applicable