

HEALTH CARE PROVIDERS GROUP INSURANCE PLAN™
STATEMENT OF HEALTH
(Please answer ALL questions)

Employee information only

Last Name _____ First Name _____ Hospital _____ Dept _____

Information about you and your dependents

1. List all persons eligible for coverage including yourself (in shaded boxes), spouse, and all eligible dependents)

Name of eligible persons (include yourself on the first line)	Relationship to you	Birthdate dd/mm/yyyy	Height feet/inches	Weight pounds	Smoker (Y/N)
	Employee				

2. Have you or any of your dependents ever consulted a physician or alternative health care provider (including herbalist, acupuncturist, massage therapist, chiropractor, or practitioner of homeopathy or naturopathy, etc) about, been treated for, or had any known indication of any of the following:
 (If "Yes", please circle which and give details in 6, over page).

	Yes	No		Yes	No
(a) Circulatory or Heart or Vascular disease, High Blood Pressure, Angina, Stroke or TIA (mini stroke), Elevated cholesterol, Chest Pain or Heart Murmur?	<input type="checkbox"/>	<input type="checkbox"/>	(i) Immune Disorder including testing for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Syndrome (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
(b) Arthritis, Gout, Rheumatism, Osteoporosis/Osteopenia, disorder of joints or limbs or spine, joint or muscle pain?	<input type="checkbox"/>	<input type="checkbox"/>	(j) Skin Disorder including Acne, Rosacea, Psoriasis or Eczema?	<input type="checkbox"/>	<input type="checkbox"/>
(c) Colitis, Crohn's, Irritable Bowel Syndrome, Ulcers, Hernia, Reflux or persistent Heart Burn?	<input type="checkbox"/>	<input type="checkbox"/>	(k) Infertility, Reproductive disorder, Menopause, Disorder of Breasts, Ovaries, Cervix or Uterus?	<input type="checkbox"/>	<input type="checkbox"/>
(d) Stomach, Intestinal, Kidney, Bladder or Liver Disorder including Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	(l) Headaches/migraines, Dizziness, Fainting, Disorder of the brain or nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
(e) Mental, Anxiety, Emotional Disorder, Depression, Alzheimer's, Dementia, Parkinson's, Seizures or Paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	(m) Sexually Transmitted Disease or infection (STD's or STI's) or recurring infections (including Cold Sores/Herpes)?	<input type="checkbox"/>	<input type="checkbox"/>
(f) Alcohol or drug dependency?	<input type="checkbox"/>	<input type="checkbox"/>	(n) Diabetes or Endocrine disorder	<input type="checkbox"/>	<input type="checkbox"/>
(g) Lung Condition, Respiratory Condition including COPD, Asthma or Allergies?	<input type="checkbox"/>	<input type="checkbox"/>	(o) Disorder of the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
(h) Cancer, Tumor or any other growth?	<input type="checkbox"/>	<input type="checkbox"/>			

3. Have you or any of your dependents ever been treated or hospitalized for or had any known indication of any Physical Impairment, Condition, Disease or Disorder not stated above? If "Yes", please give details in 6 over page. Yes No
4. Are you or any of your dependents currently taking prescription or non-prescription medications of any kind or been advised by a physician or Alternative Health Care Provider to take medication of any kind? If "Yes", please give details in 6 over page. Yes No
5. Have you or any of your dependents ever been advised to have an investigation, hospitalization or surgery which has not yet been completed? If "Yes", please give details in 6 over page. Yes No



